Meeting of the Board of Directors (in Public) 23 July 2026

Thursday 23 July 2026, 09:30 - 12:15

Trust Headquarters, Kirkstall, Fountains and Rosedale

Voting Directors - Martin Havenhand, Amanda Moat, Becky Malby, Saghir Alam, Tabitha Arulampalam, Michael Wright, Peter Reading, Kathryn Vause, Dave Green, Marc Thomas, Shona McCallum

Non-Voting Directors - Mandy Wilcock, David O'Brien, Sam Robinson

In Attendance - Rebecca Randell, Helen Edwards, Odette Colgrave

Apologies - Carol Weir, Katie Lees

Agenda

09:30 - 09:31
1 min

1. Welcome and Apologies

Information *Martin Havenhand*

Verbal

09:31 - 09:32
1 min

2. Declaration of Interests

Assurance *Martin Havenhand*

Verbal

09:32 - 09:33
1 min

3. Minutes of Previous Meetings - 21 May 2026

Approve *Martin Havenhand*

Paper

2026.05.21 Draft Minutes of BoD Public v0.4 MH.pdf (21 pages)

09:33 - 09:35
2 min

4. Matters Arising

Assurance *Martin Havenhand*

Verbal

09:35 - 09:35
0 min

5. Action Log

Assurance *Martin Havenhand*

Paper

2026.07.23 Public Action Log.pdf (1 pages)

09:35 - 09:50
15 min

6. Patient Story

Information *Dave Green*

Presentation

Resolution: The Board to note the contents of the presentation.

09:50 - 09:55
5 min

7. Chair's Report

Approval/Information/Assurance *Martin Havenhand*

Paper

Resolution: The Board to note the Chair's report.

Chair's Report (2).pdf (6 pages)

09:55 - 10:00
5 min

8. Chief Executive's Report

Information *Peter Reading*

Paper

Resolution: The Board to note the Chief Executive's report.

Chief Executive's Report JULY 2026 V1.pdf (6 pages)
Chief Executive's Report Appendix A CEO and Executive Director Objectives 2026-2027.pdf (11 pages)

10:00 - 10:15
15 min

9. 2026/27 Business Plan: Assurance and Performance Q1

Marc Thomas

Paper

Resolution:

Q1 26-27 Business Plan Update.pdf (29 pages)

10:15 - 10:20
5 min

10. Finance and Performance Committee Chair's Report

Assurance *Saghir Alam*

Paper

Resolution: The Board to note the contents of the report.

Finance and Performance Committee Chair's Report July Board.pdf (4 pages)

10:20 - 10:30
10 min

11. Finance and Performance Report

Assurance *Kathryn Vause*

Paper

Resolution:

10:30 - 10:40
10 min

12. 2026-27 Revised Capital Expenditure Plan

Assurance *Kathryn Vause*

Paper

Resolution: To provide the Trust Board with an update of the revised Capital Expenditure Plan for 2026-27.

Board 2026-27 Revised Capital Expenditure Plan.pdf (5 pages)

10:40 - 10:50
10 min

13. Operational Performance Report (M3 and July reports)

Assurance *Marc Thomas*

Paper

Resolution: The Board to note the contents of the report.

- Operational Performance Report M3 Board.pdf (11 pages)
- Operational Performance Report July Board.pdf (10 pages)

10:50 - 10:55
5 min

14. Quality Committee Chair's Report (June and July)

Assurance *Becky Malby*

Paper

Resolution: The Board to note the contents of the report.

- Quality Committee Chair's Report - June 26.pdf (3 pages)
- Quality Committee Chair's Report - July 26.pdf (3 pages)

10:55 - 11:00
5 min

15. Quality and Clinical Highlight Report

Assurance *Dave Green / Shona McCallum*

Resolution: The Board to note the contents of the report.

- Clinical and Quality Highlight Report v0.1.pdf (4 pages)

11:00 - 11:10
10 min

16. Board Assurance: Care for the Deceased

Approval/Assurance *Shona McCallum*

Paper

Resolution:

- Board Assurance - Care for Deceased Appendix 4 Management of Deceased Patients Policy.pdf (12 pages)
- Board Assurance - Care for Deceased (4).pdf (43 pages)

11:10 - 11:20
10 min

BREAK

11:20 - 11:25
5 min

17. People Committee Chair's Report

Assurance *Tabitha Arulampalam*

Paper

Resolution: The Board to note the contents of the report.

- People Committee Chair's Report.pdf (3 pages)

11:25 - 11:35
10 min

18. People and Organisational Development Highlight Report

Assurance *Mandy Wilcock*

Paper

Resolution: The Board to note the contents of the report.

- People and Organisational Development Highlight Report.pdf (8 pages)

11:35 - 11:45
10 min

19. Lord Mann Review and NHS England Actions

Mandy Wilcock

Paper

Resolution:

- Lord Mann Review NHS England Actions 2026.pdf (11 pages)
- PRN02538_Letter to NHS leaders Lord Mann Review_.pdf (4 pages)

11:45 - 11:55
10 min

20. 'Ask Peter'

Peter Reading

- Ask Peter Review and Update.pdf (3 pages)

11:55 - 12:00
5 min

21. Audit and Risk Committee Chair's Report

Assurance *Amanda Moat*

Paper

Resolution:

12:00 - 12:05
5 min

22. Board Governance Report

Information *David O'Brien*

Paper

Assurance Committees Annual Reports

- Board Governance Report (1).pdf (7 pages)

12:05 - 12:10
5 min

23. Assurance Committees Annual Reports

Assurance *David O'Brien*

Paper

Resolution:

- Assurance Committees' Annual Reports 2025-26.pdf (28 pages)

12:10 - 12:15
5 min

24. Any Other Business

Information *Martin Havenhand*

Verbal

12:15 - 12:15
0 min

25. Risks

Assurance/Information *Martin Havenhand*

Any risks raised during the meeting that require consideration of adding to Risk Registers/Board Assurance Framework

---

12:15 - 12:15
0 min

26. Date of next Board Meetings to be held in Public

- 24 September 2026

Please note: if you are unable to attend any of the above noted meetings, you must inform the Chair and the Corporate Governance Team (via email) as soon as reasonably possible.

12:15 - 12:15
0 min

27. Supporting Information

27.1. Integrated Performance Report (IPR)

Minutes of the Board of Directors Meeting (in PUBLIC)

Thursday 21 May 2026 at 09:30

Venue: Kirkstall, Fountains and Rosedale, Trust Headquarters, Wakefield

Voting Directors	Martin Havenhand	Chair
	Amanda Moat	Non-Executive Director (Deputy Chair)
	Andrew Chang	Non-Executive Director (Senior Independent
	Saghir Alam	Non-Executive Director
	Melanie Hudson	Non-Executive Director
	Marc Thomas	Deputy Chief Executive and Chief Operations
	Kathryn Vause	Executive Director of Finance
	Dave Green	Executive Director of Quality and Chief Paramedic
	Shona McCallum	Executive Medical Director
Non-Voting Directors	Mandy Wilcock	Director of People and Organisational Development
	David O'Brien	Director of Corporate Services and Company
	Carol Weir	Director of Strategy, Planning and Performance
	Sam Robinson	Chief Digital Information Officer
In Attendance	Katherine Lees	Associate Non-Executive Director
	Rebecca Randell	Associate Non-Executive Director
	Helen Edwards	Associate Director of Communications and Community
	Sam Bentley	Freedom To Speak Up Guardian (item 22)
	Emily Cole	Corporate Governance Officer
	Odette Colgrave	Corporate Governance Manager
Apologies:	Peter Reading	Chief Executive
	Becky Malby	Non-Executive Director
	Tabitha Arulampalam	Non-Executive Director

BoD26/05/1 **Welcome and Apologies**

1.1 Martin Havenhand welcomed all to the Board.

1.2 Apologies were received from Peter Reading, Becky Malby, Tabitha Arulampalam

1.3 The meeting was quorate.

BoD26/05/2 **Declaration of Interests**

2.1 No declarations of interest were reported. If any declarations of interest arose during the meeting these would be considered at that time.

BoD26/05/3 **Minutes of Previous Meeting**

3.1 The minutes of the meeting of the Board of Directors held in public on 26 March 2026 were approved as an accurate record.

3.2 **Matters arising - Financial Performance Report M11**

Kathryn Vause explained that the minutes from the previous meeting rightly outlined her concerns regarding the forecast year end capital position (as at month 11. Given significant disruption to the capital programme as a result of the Trust's Double Crewed Ambulance (DCA) convertors going into administration, there were real concerns that we would be unable to use our full capital allocation. However, Kathryn updated Board that the Trust did in fact spend the full the original allocation, plus a further £1.67m made available through national slippage. Kathryn reported this as a real benefit to staff and patients and noted the hard work of those involved in delivering so much in the last few weeks of the financial year.

BoD26/05/4 **Action Log**

4.1 There were no actions to update.

BoD26/05/5 **Patient Story**

5.1 Dave Green introduced the patient story, which was delivered by James Goulding, Chief Clinical Information Officer. The story outlined the use of a new digital solution – RapidSOS – to locate patients. The story was shared anonymously and included reference to suicide.

5.2 James Goulding outlined the clinical safety and improvement aspects of the case, with particular reference to the benefits for patients. Martin Havenhand commented on the clarity of the presentation and the key principles and thanked James Goulding for his contribution.

5.3 **Resolved:**

The Board noted the contents of the patient story.

BoD26/05/6 **Chair's Report**

6.1 Martin Havenhand presented the Chair's Report. He advised that when Andrew Chang steps down at the end of his second term as Non-Executive Director the Trust would need to appoint a new Senior Independent Director. The Board supported the recommendation that Melanie Hudson be appointed as Senior Independent Director, effective from 01 July 2026.

6.2 David O'Brien confirmed that the Senior Independent Director role also takes on the Non-Executive Director (NED) champion for Freedom to Speak Up.

6.3 Marc Thomas asked if board directors objectives could be shared. It was noted that a report would be produced for presentation to the board showing

NEDs objectives and Executive Directors objectives relating to delivery of our approved business plan.

6.4 **Resolved**
The Board noted the report.

BoD26/02/7 **Chief Executive's Report**

7.1 Marc Thomas presented the Chief Executive's Report. The Board noted the global fellowship programme, which involves paramedics travelling to Zambia. It was noted that the programme had been beneficial to both organisations, and that a future update would be brought to the Board.

7.2 Saghir Alam referred to Dying Matters Awareness Week in South Yorkshire and asked how the Trust was engaging with diverse communities. Helen Edwards advised that the volunteer campaign would help to address this by reflecting roles held by people from diverse communities. She added that NHS Charities Together funding would support work with volunteers, campaigns and community engagement colleagues.

7.3 **Resolved**
The Board noted the report.

BoD26/05/8 **Business Plan 2025/26 Closing Report**

8.1 Carol Weir presented the Business Plan 2025/26 Closing Report and highlighted the year-end position against delivery of the Trust's priorities. The Board heard that quarterly highlight reports had been provided through Senior Responsible Officers and that the report had been structured to demonstrate progress achieved, areas requiring further focus, and the actions proposed for the year ahead.

8.2 In presenting the key achievements, it was reported that performance in relation to patients had improved, including Category 2 performance being better than in the previous year and in line with the plan. Positive progress was also noted in relation to the implementation of the NHS Pathways digital triage system, staff survey results, and the impact of the YAS Together programme. Improvements in handover times were highlighted, with performance reported to be nine minutes better than plan. The Board also heard that the planned efficiencies had been delivered.

8.3 The Board noted that a number of areas had not delivered as planned, including Hear and Treat (H&T), and that further focus would be required in respect of clinical capacity, crew clear, sickness absence reduction and the benefits realisation associated with telematics. It was confirmed that these matters had been incorporated into the 2026/27 Business Plan and would continue to be monitored through the Trust's established performance and assurance arrangements.

8.4 Kathryn Vause outlined the year-end financial position and advised that the Trust had achieved a better than break-even position and reduced its underlying deficit, representing a positive direction of travel. The Board was advised that a £2.5 million surplus had been achieved and that, through

arrangements agreed via West Yorkshire Integrated Care Board (ICB) and NHS England, organisations improving their financial position would receive matched capital allocation. It was anticipated that the Trust would therefore be able to access £2.5 million of additional capital in 2026/27. In discussion, Martin Havenhand welcomed the position achieved in the context of the wider financial challenges facing organisations and emphasised the importance of maximising the benefit of the available capital funding.

8.5 During discussion, Amanda Moat sought clarification regarding the reported status of electronic Patient Record (ePR), noting that the programme had previously been described as green whereas the year-end report showed an amber rating. In response, Sam Robinson advised that the programme would previously have been rated green and remained broadly on track, with 90% of iPad devices having been rolled out; however, dependency and migration issues had created a knock-on impact which meant the programme was now behind plan and therefore appropriately reflected as amber. It was confirmed that the narrative in future reporting would be strengthened to ensure this position was clear.

8.6 Katie Lees asked how the position in relation to H&T had been presented nationally, and it was agreed that this would be picked up further within the 2026/27 reporting. Rebecca Randell sought assurance regarding slippage in the EDI workstream arising from staff absence and asked what could be done in future to mitigate the impact of such absence on delivery. In response, Mandy Wilcock advised that subject matter experts had been connected with colleagues in other ambulance trusts and support had been sought through TIDE partners; however, the work remained within a specialist field and recruitment had been challenging. Whilst this had enabled progress to continue in most areas, some of the larger pieces of work had been delayed. It was noted that additional consultancy support might need to be considered going forward.

8.7 Mandy Wilcock thanked Carol Weir and the wider team for their leadership in closing the 2025/26 Business Plan, noting that the process had strengthened organisational focus, performance management and clarity of objectives, including within appraisal discussions. Martin Havenhand agreed and commented that the report provided a clear account of the full planning cycle from commencement to year end.

8.8 Melanie Hudson welcomed the clarity of the report and asked that future reporting make more explicit which actions had not been achieved within the year and had been carried forward. Carol Weir confirmed that these had been built into the 2026/27 Business Plan and would continue to be monitored. Marc Thomas added that future reports will distinguish more clearly those actions that were part of multi-year programmes, such as H&T, with milestones identified across successive years.

8.9 **Resolved**

The Trust Board:

- Noted the year-end delivery position against the 2025/26 Business Plan;
- Took assurance from the areas of delivery and impact set out in this report;

- Noted the areas where planned benefits were not fully realised and the corrective actions embedded in the 2026/27 Annual Business Plan;
- Supported the planned activity for 2026-27aligned to the agreed business plan, as noted in the paper.

BoD26/05/9 **Annual Business Plan 2026/27 Update**

9.1 Carol Weir introduced the Annual Business Plan 2026/27 and advised that the plan reflected Year 3 of the Trust's strategy, with a focus on three priority areas for the year ahead.:

1. improving the right response through increased H&T and reduced emergency department conveyance;
2. improving operational productivity and performance, including Category 2;
3. supporting staff through reduced sickness absence.

9.2 The Board heard that the plan would be delivered through the Trust's existing performance and assurance framework, with oversight of the H&T programme to continue through the Operational Performance Group meetings. It was noted that the plan placed particular emphasis on improving productivity and performance, including delivery of Category 2 response times of under 25 minutes, reducing sickness absence, and supporting delivery through the Clinical Response Model and the YAS Together programme. The Board also noted that delivery would remain challenging and that the Trust would continue to work with system partners to improve handovers and develop alternative pathways for patients.

9.3 During discussion, Amanda Moat asked whether sufficient consideration had been given to the impact of changes to the sickness policy and the extent to which responsibility had been delegated to Team Leaders. Mandy Wilcock advised that the approach aimed to strengthen management expectations while maintaining a compassionate and supportive culture, with a clear balance between effective attendance management and staff wellbeing. Marc Thomas noted the significant level of involvement required from Area Operations Managers (AOMs) and queried whether there was scope to review how the Team Leader role continued to evolve. Mandy Wilcock confirmed that this could be reviewed further within the operational context.

9.4 The Board discussed the importance of setting clear expectations in relation to attendance and return to work, including for newly trained staff, and considered whether any comparative review of previous and current approaches to sickness management would be beneficial. In response, Mandy Wilcock reported that the Trust's data did not indicate that younger staff were the principal driver of absence levels and that the predominant pattern related to older staff with long-term health conditions. It was acknowledged, however, that further feedback from Team Leaders would be valuable in understanding local variations and identifying any additional support required.

9.5 Martin Havenhand referred to emerging national discussion regarding sickness certification and return to work support, and suggested that it would be helpful for the Trust to remain sighted on any pilot or national developments that might support more timely rehabilitation and return to work arrangements. Melanie Hudson noted that a 0.5% reduction in sickness absence represented a

significant workforce impact in full-time equivalent terms and requested that this be clearly articulated in future reporting. **Mandy Wilcock agreed to provide clarification on the quantified impact of the proposed 0.5% reduction in sickness absence.**

Action: Mandy Wilcock

9.6 Carol Weir noted that the Trust needed to demonstrate more clearly the improvements being achieved through the plan, including the relationship between productivity initiatives and performance gains such as reductions in Category 2 response times. **It was agreed that future public reporting should more explicitly highlight productivity benefits as a distinct component of delivery.**

Action: Carol Weir

9.7 Andrew Chang commended the quality of the document and suggested that it should be made more widely available across the Trust. Martin Havenhand also emphasised the importance of reflecting, through Board reporting and communications, the strength of the Trust's engagement with partners and the positive benefits this was delivering for patients.

9.8 **Resolved**
The Board approved the 2026/27 Annual Business Plan.

BoD26/05/10 **Trust Revenue Financial Plan 2026/27 to 2028/29**

10.1 Kathryn Vause confirmed that the Trust Revenue Financial Plan for 2026/27 to 2028/29 had been approved previously by the Board of Directors in private session.

10.2 It was noted that the plan was based on a break-even position and assumed receipt of all expected funding together with delivery of the 4% efficiency requirement. The Board noted that £2.1 million of the plan remained unidentified.

10.3 Marc Thomas advised that, within 999 Operations, further work was required in relation to budget management and financial decision-making arrangements. He noted that these arrangements were complex and that greater clarity was needed regarding the level at which decisions were being taken, including in relation to overtime. He acknowledged that there was scope for improvement.

10.4 In response to a question from Martin Havenhand regarding whether sufficient assurance could be provided that a robust and resilient plan was in place, Marc Thomas stated that the issues were recognised and that work was underway to develop a plan. However, he advised that he was not yet able to provide full assurance, as a firm plan had not yet been fully established.

10.5 Martin Havenhand emphasised that he did not wish the Trust to carry an unmanaged risk in relation to delivery of the financial plan.

10.6 Kathryn Vause advised that regular performance review meetings were in place and confirmed that this matter would continue to be reviewed. Andrew

Chang concurred with this approach and in his capacity as Chair of the Finance and Performance Committee, referred to the Committee's consideration of this matter.

10.7 **Resolved**
The Trust Board:

- Noted the financial framework for 2026/27.
- Noted the underlying recurrent deficit position.
- Noted the risks to delivery of the plan.
- Approved the break-even financial plan for 2026/27.
- Approved budgets to be set within the parameters of this plan.

BoD26/05/11 **Trust Capital Plan, 2026/27 to 2029/30**

11.1 Kathryn Vause presented the Trust Capital Plan for 2026/27 to 2029/30 and advised that the plan may require adjustment during the year, subject to assumptions regarding access to capital funding through the bidding process. It was noted that these funds were not guaranteed.

11.2 The Board noted that the Trust had fully utilised its capital allocation for 2025/26 and had also been able to bring forward a proportion of capital expenditure from 2026/27 in order to maximise the use of available funding.

11.3 It was confirmed that not all proposed schemes would be affordable within the available funding envelope and that prioritisation would therefore be required, with further detail to be presented to the Board as appropriate.

11.4 It was noted that this area of financial risk should be included as part of the induction for the new Non-Executive Director in his role as incoming Chair of the Finance and Performance Committee.

Action: Kathryn Vause

11.5 Melanie Hudson sought assurance regarding any potential patient risk associated with the introduction of electric vehicles, particularly in relation to whether these vehicles would be deployed only at stations with appropriate charging infrastructure.

11.6 In response, Kathryn Vause confirmed that an assessment had been undertaken which identified that electric vehicle deployment would not be suitable in all areas due to limitations in vehicle range. The Trust had mapped those areas where use would be viable and intended to undertake a limited trial in appropriate locations. It was noted that only one electric vehicle had been received to date and, as such, the scope for extensive trialling was currently limited.

11.7 Melanie Hudson referred to the quality impact assessment within the paper and asked whether there were any quality or patient safety risks arising from the proposals that should be explicitly reflected. Kathryn Vause confirmed that no quality risks had been identified in relation to the proposals set out in the Trust Capital Plan.

11.8 Saghir Alam asked what mitigating actions were in place in respect of price inflation and other longer-term financial risks. In response, Kathryn Vause advised that the 2026/27 plan had been developed alongside the revenue plan and that known cost pressures had been considered as part of the financial planning process.

11.9 The Board was advised that one key area of pressure related to pay awards. A higher figure than originally anticipated had subsequently been agreed. Given the Trust's workforce profile, including a significant number of Agenda for Change staff, this had represented a material consideration. It was noted that the relevant uplift had now been received, providing assurance from a pay perspective.

11.10 Kathryn Vause further advised that, since submission of the planning return, increased fuel costs had emerged as an additional pressure for the Trust, reflecting the scale of fuel usage across operations. It was noted that these increases also had implications for suppliers, including patient transport services, and that this position would continue to be reviewed throughout the year.

11.11 Sam Robinson added that technology costs were also expected to increase significantly. Work undertaken with Kathryn Vause's team indicated an anticipated increase of approximately 20% over the coming years, with at least a 30% increase projected in the next financial year. It was noted that this was not unique to Yorkshire Ambulance Service but reflected broader sector-wide pressures within information technology. Whilst the risk could be forecast, the precise financial impact remained uncertain.

11.12 Kathryn Vause acknowledged that it was highly unlikely the Trust would receive any additional capital funding during the year. Should further financial pressures arise, priorities within the plan would need to be reviewed and managed accordingly as part of the Trust's overall financial management arrangements.

11.13 Andrew Chang confirmed that the Finance and Performance Committee had reviewed the Trust Capital Expenditure Plan and had supported the proposal presented to the Board.

11.14 **Resolved**
The Trust Board:

- Noted the available capital funding.
- Approved the 2026/27 to 2029/30 Trust capital expenditure plan.
- Noted the risks in section 6.

BoD26/05/12 **Corporate Risk and Board Assurance Framework**

12.1 David O'Brien presented the quarter 4 Corporate Risk Register and Board Assurance Framework report, which provided assurance on the Trust's principal risks at year end. The Board noted that the report included an executive summary and a more detailed review of a number of risks where score movement or additional scrutiny was required.

12.2 In discussion on the recruitment and retention risk within the Emergency Operations Centre, Amanda Moat advised that she was not comfortable relying on a single metric to assess progress and suggested that a broader range of indicators should be considered. It was agreed that this would be explored further at a future Board Strategic Forum session.

Action: David O'Brien

12.3 Martin Havenhand noted that a number of new corporate risks had been opened and requested further detail on Risk 727 in relation to arrangements with blue-light partners. In response, Dave Green advised that the Trust had historically operated under informal arrangements with police and fire service partners, but that the scale of the request had increased over time. Work was therefore underway to formalise these arrangements through a service level agreement, including consideration of an appropriate charging mechanism. The Board noted that discussions with partners were ongoing and that the position would be developed further over the coming period.

12.4 Rebecca Randell queried the position in relation to Risk 582 (Loss of Blood Products) and the reference to errors relating to records. Shona McCallum advised that the matter would require further review and noted that she was presently aware of only one incident.

12.5 The Board discussed Risk 612 relating to 999 West handovers. Martin Havenhand noted the inclusion of this risk on the risk register and requested clarification on the reason for its reintroduction. David O'Brien advised that handover risks had previously been de-escalated following improvement in transfer of care arrangements, but had subsequently required re-escalation due to further delays. The Board noted that performance had since begun to improve steadily.

12.6 Martin Havenhand sought assurance in relation to the West Yorkshire handover position, noting that whilst the Board understood the nature of the issue, it was important to be clear what assurance could be taken from the controls in place. In response, Marc Thomas advised that the 45-minute handover process was not being followed consistently and that leaders across the West locality were investigating the reasons for this. It was noted that the principal issue related to inconsistent adherence by partner organisations to agreed standard operating procedures

12.7 Marc Thomas added that handover delays in Humber and North Yorkshire and South Yorkshire had both reduced, whereas improvement in West Yorkshire had been slower and now represented the principle area of concern, particularly in Bradford, Pinderfields and Airedale. It was confirmed that these locations would remain a focus for further work.

12.8 In relation to Risk 737, Marc Thomas advised that external partners had been given notice on their contract. The risk had subsequently been mitigated through use of internal resource and the appointment of an external company, resulting in a reduction in score from 15 to 12, although this was not yet reflected in the report presented.

12.9 The Board also noted the opening of new Risk 735 in relation to COPD care, which had initially been scored at 15 and had subsequently reduced to 12 following mitigating action. Dave Green advised that the risk had been managed effectively to date and that best practice would continue to be promoted through the Trust Executive Group.

12.10 In relation to Risk 725, the Board noted a reduced score associated with compliance regarding Freedom of Information performance. It was reported that legal compliance had previously improved from approximately 70% to above 90–95%, but that performance had since declined and would require continued monitoring.

12.11 **Resolved**
The Committee:

- Noted the position regarding Board Assurance Framework (BAF) strategic risks at the end of 2025/26 and transition to 2026/27.
- Identified no areas that require further information or additional assurance.

BoD26/05/13 **Finance and Performance Committee Chair's Report**

13.1 Andrew Chang in his capacity as Chair of the Finance and Performance Committee, presented from the meeting held on 16 April 2026.

13.2 The Committee raised an Alert on Information Governance training compliance: 87.85% at 31 March 2026 versus a 90% target and 95% aspiration. Having questioned whether the 90% target remains appropriate and referred this to People Committee, it now recommends Board discussion on the target and improvement approach.

13.3 The Board expressed concern regarding the matter having been escalated and agreed that the position was not acceptable. Martin Havenhand emphasised the need to understand the underlying processes and sought assurance on the actions that would be taken by Executive colleagues to address the issues identified. The Board noted that one of the matters was subject to potential review by NHS England and could have implications for the Trust's segment status and Care Quality Commission assessment.

13.4 The Board requested clear assurance on the controls in place together with a defined action plan to address the issues raised.

Action: David O'Brien / Mandy Wilcock

13.5 In discussion on the proposed 95% target, Mandy Wilcock advised that whilst this should remain an aspiration, it would be challenging to achieve consistently in the context of turnover and sickness absence. It was agreed that the matter would be considered further through the People Committee.

13.6 **Resolved**
The Board noted the contents of the report.

BoD26/05/14 **Operational Assurance Report**

14.1 Marc Thomas presented the Operational Assurance Report. The Board received a Business Intelligence presentation on long-term performance trends, including comparison of Yorkshire Ambulance Service performance against national figures from April 2018 to the latest available period.

14.2 The Board noted updates on mean 999 call answer times, Category 1 mean and percentage performance, Category 2 mean performance, Hear & Treat rates, conveyance to hospital rates, and sickness absence. The Board noted management's view that these data trends are reflected in current plans and strategic priorities.

14.3 The Board noted the three priorities presented: improving the right response through increased H&T and reduced emergency department conveyance; improving operational productivity and performance, including Category 2; and supporting staff through reduced sickness absence.

14.4 Marc Thomas highlighted that Category 1 mean response performance had remained stable and strong, whilst a number of other measures continued to reflect the residual impact of system pressures and workforce challenges. Martin Havenhand referred to the final slides within the presentation and asked whether they demonstrated that the Trust had not fully recovered from the impact of the COVID-19 period, and what ongoing legacy factors remained. Mandy Wilcock advised that sickness absence continued to be a significant contributory factor.

14.5 In discussion on Category 1 on-scene performance, Katie Lees asked about the peak observed during 2024 and whether categorisation may previously have been inaccurate. Dave Green confirmed that categorisation was now being undertaken more accurately, noting that this remained dependent on the information available from patients at the point of call.

14.6 The Board discussed the significant gap between Yorkshire Ambulance Service and the England average in relation to Hear and Treat performance and the associated rate of conveyance to hospital. It was noted that the Trust appeared to convey a greater proportion of patients to hospital and that this may in part reflect the relative availability of alternative pathways across the region. Martin Havenhand sought assurance as to whether this position was evidenced and queried why other ambulance services appeared to have access to a broader range of alternatives. Marc Thomas advised that further national work was underway through NHS England to review hear and treat arrangements and that this was expected to provide greater insight into pathways used elsewhere, including community-based options, care coordination and single points of access.

14.7 Shona McCallum confirmed that national review work was also mapping the alternative pathways available to ambulance trusts and that, in comparison with other areas, Yorkshire currently had fewer services in place to support avoidance of conveyance. The Board noted the importance of continued engagement with ICBs and acute hospital partners regarding the direct services and pathways required to improve performance in this area.

The Board welcomed the external review support being undertaken in relation to hear and treat, including the evidence this would provide to strengthen improvement work. Shona McCallum advised that newly appointed expert support would also assist this programme.

14.8 Andrew Chang asked whether the Trust could be fully confident in its explanation for the gap in conveyance rates. In response, Marc Thomas acknowledged that there was more to understand about decision-making on scene, and Shona McCallum added that stronger senior clinical input would be required, particularly in relation to complex decisions about non-conveyance. Amanda Moat noted that where patients had previously been unsuccessful in accessing alternatives, they may be less likely to continue seeking such support, and that momentum would need to be built to change this pattern.

14.9 In discussion on sickness absence, Melanie Hudson asked whether workforce growth may have influenced the position and it was confirmed that the workforce had increased since 2023, with the Trust's sickness rate remaining broadly similar to that of other ambulance trusts. Martin Havenhand requested that future presentations differentiate more clearly between areas of the service, including comparisons between 999 and 111, in order to support a more informed understanding of where absence was occurring.

14.10 Mandy Wilcock advised that some trusts made greater use of alternative duties, and that this was being explored in more detail locally, noting that operational staff could in some cases only undertake frontline roles. Andrew Chang queried how West Midlands Ambulance Service accounted for its lower reported rate, and it was noted that this may in part reflect the use of alternative duties, including home-based work.

14.11 Carol Weir noted that these measures formed part of the key metrics within the national oversight framework. Melanie Hudson highlighted continuing concern in relation to improvement in call handling performance. Marc Thomas advised that, whilst progress had been made, there remained a number of areas where further improvement was required and that these had been incorporated within the Trust's priority objectives.

14.12 Martin Havenhand emphasised the importance of being able to demonstrate a clear link between the activities underway and the benefits and outcomes expected, and asked that future reporting support Board challenge where planned actions were not delivering the intended improvement so that approaches could be reviewed and adjusted in a timely way. Rebecca Randell also drew attention to an inconsistency in the recruitment data for Emergency Operations Centre (EOC) clinical staffing between the appendix and the main report. It was confirmed that an updated Month 1 version had been produced and that the annex contained an error, with the figures in the main report being the more accurate position.

14.13 **Resolved**
The Board noted the contents of the report.

BoD26/05/15 **Financial Performance Report – Month 1 (April 2026)**

15.1 Kathryn Vause presented the Financial performance report (Month 1) for April 2026.

15.2 The Board noted the key highlights from the month 1 financial position, including a revenue underspend of £86k against plan and a forecast year-end position of break-even. Kathryn Vause advised that the principal pressure at this stage related to fuel costs. In month 1, diesel expenditure was approximately £100k above plan. Although fuel usage had reduced, prices had increased by more than 30%, with the average price reported at £1.74 per litre, which was above the level assumed within the plan. It was noted that forecasting remained challenging given the volatility in both usage and price.

15.3 The Board received an update on the productivity and efficiency programme, including the position in relation to unidentified savings, in-year pressures and associated benefits. Kathryn Vause advised that further cost reductions had been identified within budgets which were expected to mitigate the remaining unidentified element, and she expressed confidence that this could be addressed.

15.4 It was noted that delivery targets remained embedded across all budgets, although a number of schemes continued to be assessed as high risk, particularly within IT. These would continue to be monitored closely through the Trust's financial governance arrangements.

15.5 In relation to capital, the Board noted that expenditure was £2.8 million below plan at month 1, with no immediate concerns reported. It was recognised, however, that the liquidation of one of the Trust's conversion suppliers had affected delivery timescales and that some schemes had therefore been brought forward from 2027/28 to support continued programme delivery.

15.6 Martin Havenhand asked whether a clearer schedule could be provided showing the cost improvement and efficiency figures that the Trust was required to deliver. In response, Kathryn Vause confirmed that this information was available and could be reported to provide assurance. She further advised that the efficiency programme continued to be reported through the Finance and Performance Committee and that revised oversight arrangements were being established to strengthen in-year monitoring. It was noted that all Executive Directors would be members of this group, which would review delivery of the in-year plan and support future benchmarking of efficiencies.

15.7 The Board noted that the revised oversight group would report through both the Finance and Performance Committee and the Trust Executive Group, and that Peter Reading would chair the group.

15.8 **Resolved**

The Trust Board noted:

- The Trust's financial performance for April 2026.
- All associated risks.

BoD26/05/16 **Quality Committee Chair's Report**

16.1 Melanie Hudson in her capacity as Deputy Chair of the Quality Committee, presented the reports from the meetings held on 09 April and 07 May 2026.

16.2 The Board noted that there were no alerts arising from the April report presented. In discussion, the Board considered whether further review was required in relation to patients who were being conveyed to hospital on a recurring basis. Dave Green advised that, during periods of significant handover delay, conveyance rates had improved and noted that clinical decision-making on scene involved balancing risk, the availability of alternative pathways, and what was in the patient's best interests. The Board acknowledged the potential influence of human factors in these decisions.

16.3 Two alerts had been identified in the May report, relating to medicines management and mortality reviews. Martin Havenhand emphasised that the Board should maintain a clear focus on the alerts reported, particularly the mortality alert. In response, Shona McCallum advised that the Trust did not yet have a sufficiently effective mortality governance structure in place. This had been identified through internal audit work. Whilst no immediate concerns had been identified, it was acknowledged that the governance arrangements required further strengthening.

16.4 In relation to medicines management alert, the Board was advised that the technical connectivity issues identified regarding the app were being addressed and that appropriate plans were in place. Sam Robinson confirmed that the Trust was taking a proactive approach to resolving the issues.

16.5 **Resolved**

The Board noted the contents of the report.

BoD26/05/17 **Quality and Clinical Highlight Report**

17.1 Dave Green presented the Quality and Clinical Highlight Report.

The Board noted that internal audit actions had been addressed. It was further reported that complaint response performance stood at 23% against an internal target of 10%. The Board heard that the Patient Relations team had been working intensively to improve complaint handling, including progressing sign-off arrangements during periods of annual leave, and that responses were now being issued more quickly.

17.2 An update was provided on the use of text-based self-care advice for patients, enabling advice and links to be issued directly by text message. It was noted that this had been introduced as part of a quality improvement project, piloted in Hull, and that there was strong interest in extending the approach more widely across the workforce.

17.3 Shona McCallum reported on the initial review meeting at which variations in practice were identified in the way DATIX was being used across the organisation. A task and finish group had been established to review current usage, ensure the system was being used correctly and consistently, and report back within the next month.

17.4 Amanda Moat asked whether there was a longer-term strategy for DATIX. In response, Dave Green advised that the Trust intended to remain with DATIX, but acknowledged that the current system was not yet being used to its full potential. Benchmarking had been undertaken and had not identified a perfect alternative solution. It was noted that, as the Trust had moved from the previous DATIX service, there was now an opportunity to make better use of the current platform.

17.5 The Board noted that a small amount of additional resource would be required to support delivery of training programmes and that this work would need to be widened on a Trust-wide basis. The Board received an update on the Quality Assurance Programme, which formed part of the Trust's response to an audit recommendation.

17.6 Dave Green advised that, following the transition to Patient Safety Incident Response Framework (PSIRF), the Trust was seeking to strengthen how lessons learned were identified and embedded through the quality assurance process. This included clearer visibility of action plans and the supporting governance arrangements to ensure that improvements could be tracked and evidenced.

17.7 **Resolved**
The Board noted the contents of the report.

BoD26/05/18 **People Committee Chair's Report**

18.1 Mandy Wilcock presented the People Committee Chair's Report arising from the meeting of the Committee.

18.2 The Board was advised that two advise notes remained under consideration, relating to employment tribunals and workforce supply risk relating to a new clinical skills assessment process for graduate paramedic recruits.

18.3 The Committee had considered the arrangements in place for candidate assessment and progression, including the opportunity for applicants to undertake a second assessment before progressing to interview. It was reported that engagement was taking place with higher education institutions to address areas where applicants had been unable to demonstrate the required competence in core areas.

18.4 Dave Green and Dawn Adams would meet with representatives of the higher education institutions to discuss the gaps identified. Board members were advised that this formed part of a wider national conversation regarding expectations and consistency of standards.

18.5 During discussion, Martin Havenhand expressed concern regarding the position outlined. In response, assurance was provided that the approach was informed by educational expertise and sought to ensure that applicants were given an appropriate opportunity to re-sit assessments where suitable.

18.6 Rebecca Randell raised a query in relation to the curriculum, and Dave Green confirmed that he would take this discussion outside of the meeting. The Board also noted that recruitment and establishment levels continued to be

monitored closely, including full time equivalent requirements. Whilst attrition had improved, it was recognised that the organisation did not currently require the same level of recruitment as in previous years, and that the response would continue to be managed over the medium term.

18.7 Andrew Chang declared his interest during this item due to being a member of York St Johns' for Higher Education Institution.

18.8 **Resolved**
The Board noted the contents of the report.

BoD26/05/19 **People and Organisational Development Highlight Report**

19.1 Mandy Wilcock presented the People and Organisational Development Highlight Report.

19.2 Following a two-week extension to 14 April 2026, appraisal and career conversation compliance reached 89%. Excluding the Emergency Operations Centre, compliance would have been 93% and on target.

19.3 Appraisal plans are monitored through regular performance meetings, with service areas required to present monthly delivery plans. Some areas remained challenged, with further work underway on information technology support and team objectives.

19.4 The position on senior appraisals will remain open until the end of June and continue to be monitored through the dashboard.

19.5 A developing risk relating to bank staff management and compliance arrangements will be presented to the People Committee.
The Board noted forthcoming legislative changes, including day one rights, flexible working, harassment protections and time off to vote. Members also noted the potential for further industrial action, a possible extension to tribunal claim timescales from three to six months, and the removal of some financial caps.

19.6 It was reported that average timescales for long-term cases were 18.9 weeks, with the quickest concluded in around 16 weeks. Sexual safety cases could take longer, particularly where police involvement was required. Work was underway to separate police-related cases and a disciplinary review group had been established to improve timescales and address the impact of delays.

19.7 In relation to discrimination cases, the Board noted that alternative duties and reasonable adjustments remained a priority. The Trust continued to work with solicitors on tribunal cases and recognised that further action would be required in this area.

19.8 **Resolved**
The Board noted the contents of the report.

BoD26/05/20 **YAS Together Culture Development Programme End of Year Report 2025/26**

20.1 Mandy Wilcock presented the report and drew the Board's attention to a number of key matters arising. The Board noted that the focus for Years 3 and 4 would centre on a number of specific areas, including the quality element and the area of outstanding practice, with further detail to be brought back in due course. It was reported that the cultural maturity assessment demonstrated sustained improvement over the previous three years, providing assurance of positive progress across the organisation.

20.2 The Board heard, however, that progress across the YAS Together pillars was not yet consistent. While some pillars were more established, further work was required in relation to the Grow and Care Together themes, particularly around career progression and violence reduction.

20.3 It was acknowledged that greater consistency was required across these areas and that communication between leaders and staff remained a challenge. In response to a question from Amanda Moat regarding capacity and resources, Mandy Wilcock confirmed that these matters were reflected within the Trust's priorities and advised that sufficient capacity was currently in place.

20.4 Martin Havenhand commented that the YAS Together programme ran in parallel with the organisation's approach to developing its people and queried whether the programme was being sufficiently resourced to deliver the Trust's strategy, including whether there were any aspects of the programme requiring further improvement. During discussion, the Board emphasised the importance of the Executive Team continuing to review and re-evaluate the position, to ensure that the intended outcomes were delivered.

20.5 Andrew Chang referred to the earlier discussion regarding employment tribunals and queried whether there may be a correlation between the issues highlighted within the report and the number of tribunal cases, asking whether the relevant data was available and how success would be measured.

20.6 In response, Mandy Wilcock advised that the Employee Relations report submitted to the People Committee was reviewed in detail and that a number of cases related to matters such as sexual safety and reasonable adjustments. She further noted that it had become easier for cases to proceed to tribunal and confirmed that attention was being given to understanding those cases which had not been successfully defended. The Board also heard that a number of cases had been withdrawn, whilst in other instances the tribunal had indicated that insufficient information had been provided.

20.7 Mandy Wilcock confirmed that thresholds had changed and that all relevant matters continued to be reviewed through the appropriate panel arrangements. The Trust does have sufficient resources in order to deliver our strategy.

20.8 **Resolved**
The Trust Board:

- Noted the progress and impact of the YAS Together Culture Development Programme during 2025/26, evidenced through NHS Staff Survey trends from 2024 to 2025
- Noted the Culture Maturity Framework assessment and continued progression
- Supported delivery of the 2026/27 priorities to address identified risks and sustain cultural improvement.

BoD26/05/21

Sickness Reduction Plan

21.1 Mandy Wilcock highlighted the principle matters arising from the report. The Board noted that the plan aligned fully with Trust Priority 3 in relation to clear governance and performance oversight, and that delivery would be monitored through the People Committee, the Trust Executive Group and the Board.

21.2 The Board heard that the work was focused on three principal areas: improving support for mental health and wellbeing in order to help prevent sickness absence; ensuring that staff were supported to return to work effectively and sustainably; and strengthening the use of alternative duties and workplace adjustments for colleagues with longer-term health conditions.

21.3 It was reported that the approach to reducing sickness absence was underpinned by a quality improvement programme, with targeted activity focused on priority areas. Six stations had been reviewed in detail, with three demonstrating consistently strong performance in relation to sickness absence, and this work was being led through a quality improvement approach to better understand the interventions contributing to positive outcomes.

21.4 The Board noted that this work also aligned with Trust Priority 2 in respect of matching resource with demand. It was further recognised that factors such as rostering arrangements, relief rota cover and annual leave patterns could all have an impact on staff availability and sickness absence levels.

21.5 Martin Havenhand requested further assurance regarding the reduction plan and emphasised the importance of presenting clear headline information to the Board. It was acknowledged that the report contained a significant level of detail and that future reporting would seek to provide the Board with an appropriate level of concise assurance.

21.6 Carol Weir confirmed that a detailed plan sat beneath the overarching approach and advised that the articulation of clear goals would be strengthened further. Melanie Hudson referred to the use of alternative duties and queried whether this approach was demonstrably effective, noting the potential for a reduction in sickness absence to have a consequential impact on operational performance. In response, Mandy Wilcock provided assurance that the quality and effectiveness of alternative duty arrangements would continue to be monitored.

21.7 In relation to Team Based Working, the Board noted that this remained linked to Trust Priority 2. Marc Thomas advised that the matter had been considered by the Trust Executive Group two weeks previously and that a further update would be brought to the Board in July 2026.

21.8 Martin Havenhand commented that it will be necessary for the Board to receive assurances that a clear absence reduction plan was in place and that the actions were delivering the desired outcomes.

21.9 The Board noted that the plan was not being presented for approval at this stage and that a further report, with a more detailed action plan, would be received by the Board in June 2026.

Action: Mandy Wilcock

21.10 **Resolved**
The Trust Board:

- Noted the data analysis undertaken to design the plan.
- Noted that the Sickness Absence Reduction Plan for 26/27 report would be presented to the June board for approval.
- Supported the governance of this plan via the People and Culture Group with assurance through the People Committee.

Sam Bentley joined the meeting at 1200

BoD26/05/22 **Freedom To Speak Up Report**

22.1 Sam Bentley presented the Freedom to Speak Up report. Amanda Moat sought clarification regarding the source of the data presented. In response, the Board was advised that the information was drawn from the Workforce Race Equality Standard, Human Resources casework and Employee Relations cases, and that it was possible to distinguish between matters relating to bullying and harassment. It was further noted that regular discussions took place through the People and Culture Group in order to understand themes emerging across teams, identify any concerns being raised and ensure appropriate visibility of issues.

22.2 Melanie Hudson asked whether future reporting could include data relating to protected characteristics in order to provide the Board with a clearer understanding of the profile of those raising concerns. She also asked for assurance regarding whether cases progressed into formal processes and whether themes and findings were shared with other groups.

22.3 In response, the Board was advised that the number of cases progressing into formal processes could be tracked and monitored. The Board also heard that demographic information was requested from staff, although completion rates remained low. It was noted that concerns were not always raised in face-to-face settings and could also be received by email or telephone.

22.4 It was further noted that cases were revisited at the point of closure in order to support the ongoing capture of relevant information and learning. The Board noted that, whilst this information was not routinely reported through the Women and Allies Network, engagement did take place through other staff network groups as appropriate.

22.5 Andrew Chang advised the Board that Melanie Hudson would assume the role of Non-Executive Director lead in support of Freedom to Speak Up and would

hold regular meetings with the Chief Executive and the Freedom to Speak Up Guardians.

22.6 **Resolved**
The Trust Board:

- Noted the progress and developments in the Freedom to Speak Up (FTSU) function
- Took assurance from the actions underway to strengthen the speaking up culture
- Supported the next steps for FTSU.

Sam Bentley left the meeting at 1215

BoD26/05/23 **Audit and Risk Committee Chair's Report**

23.1 Amanda Moat presented the Audit and Risk Committee Chair's Report and advised that the Committee had approved its Terms of Reference. The Board received an update in relation to the annual accounts and internal audit matters, including the Head of Internal Audit Opinion, which was anticipated to be Moderate.

23.2 During discussion, Martin Havenhand expressed concern regarding the movement in assurance and sought clarification as to whether this reflected a deterioration in delivery against agreed actions. In response, David O'Brien advised that a number of actions arising from two separate reports had not been completed within the required timescales. However, he provided assurance that performance had improved significantly, with 59% of actions completed in the period June to January, rising to 94% between February and May, including two months in which completion reached 100%. He further advised that the controls implemented since January had been effective and that the organisation was now in a much stronger position. A report would be brought to the Board in July to provide assurance regarding the position on audit actions.

Action: David O'Brien

23.3 The Board emphasised the importance of ensuring that actions arising from internal audit and other assurance reports are delivered within agreed timescales. It was noted that where delivery is at risk, this should be identified promptly and revised timescales agreed through the appropriate governance process.

23.4 **Resolved**
The Trust Board:

- The Trust Board is asked to note the contents of the report and action items in the alert section.

BoD26/05/24 **Board Governance Report**

24.1 David O'Brien presented the Board Governance Report and provided an update on recent developments relating to Board governance.

24.2 The Board noted that: approval had been received for the appointment of a new Non-Executive Director; and that Melanie Hudson had been appointed as

the new Senior Independent Director and the NED champion for Freedom to Speak Up.

24.3 The Board also received the revised Terms of Reference for the Audit and Risk Committee for approval.

24.4 **Resolved**
The Trust Board:

- Noted the position regarding the recruitment process for a Non-Executive Director.
- Noted the arrangements regarding the Senior Independent Director
- Approved the Audit and Risk Committee Terms of Reference for 2026/27.

BoD26/05/25 **Any Other Business**

25.1 There were no items of any other business.

BoD26/05/26 **Risks**

26.1 A potential new risk was identified relating to the impact of the Employment Rights Act 2025. This would be investigated further and raised via the Trust's established risk management processes as appropriate.

BoD26/05/27 **Date and Time of Next Meeting**

27.1 The next meeting is scheduled to take place on Thursday 23 July 2026.

The meeting closed at 12:55.

CERTIFIED AS A TRUE RECORD OF PROCEEDINGS

_____ CHAIRMAN

_____ DATE

YAS Trust Board Committee Action Log 2026-27							
Item No	**Committee/ Group**	**Meeting Date**	**Action**	**Lead**	**Estimated Closure Date**	**Updates (When, Where, What)**	**Status**
BoD26/05/9.5	BoD Public	2026.05.21	**Annual Business Plan 2026/27 Update** Mandy Wilcock agreed to provide clarification on the quantified impact of the proposed 0.5% reduction in sickness absence.	Mandy Wilcock	Jul-26		OPEN
BoD26/05/9.6	BoD Public	2026.05.21	**Annual Business Plan 2026/27 Update** It was agreed that future public reporting should more explicitly highlight productivity benefits as a distinct component of delivery.	Carol Weir	Jul-26		OPEN
BoD26/05/11.4	BoD Public	2026.05.21	**Trust Capital Plan, 2026/27 to 2029/30** Include this area of financial risk as part of the induction for the new Non-Executive Director in their role as incoming Chair of the Finance and Performance Committee.	Kathryn Vause	Jul-26	The Board noted that not all proposed capital schemes would be affordable within the available funding envelope and that prioritisation would be required, with financial risk to be reflected in Non-Executive Director induction arrangements.	OPEN
BoD26/05/12.2	BoD Public	2026.05.21	**Corporate Risk and Board Assurance Framework** An item on EOC call handling capacity, productivity and performance, to include a wide range of metrics, to be scheduled for a future Board Strategic Forum	David O'Brien	Sep-26	The Board discussed recruitment and retention risk within the Emergency Operations Centre and queried whether reliance on a single metric was sufficient to assess progress. **Update 17.7.26 The April Board Strategic Forum received an item on EOC call handling performance and recovery plans. A future Board item will provide assurance on a broad range of EOC indicators. Scheduled for October strategic forum.**	RECOMMENDED FOR CLOSURE
BoD26/05/13.4	BoD Public	2026.05.21	**Finance and Performance Committee Chair's Report** 'As part of the scheduled Information Governance reporting to the Finance and Performance Committee, provide a SMART action plan to achieve Information Governance training compliance	David O'Brien / Mandy Wilcock	Sep-26	**Update 17.7.26 An assurance report and action plan will be taken to Finance and Performance Committee on 10 September and then to Board on 24 September.**	OPEN
BoD26/05/21.9	BoD Public	2026.05.21	**Sickness Reduction Plan** - Present a further report, including a more detailed action plan, to the Board in June 2026.	Mandy Wilcock	Jun-26	The Board noted that the Sickness Absence Reduction Plan was not yet being presented for approval and that a further report with a more detailed action plan would be required. **Update: Presented at June Private Board. Action recommended for closure.**	RECOMMENDED FOR CLOSURE
BoD26/05/23.2	BoD Public	2026.05.21	**Audit and Risk Committee Chair's Report** Bring a report to the Board in July to provide assurance regarding the position on audit actions.	David O'Brien	Jul-26	**Update 17.7.26 An audit actions asssurance report is included on the agenda for the BoD Private meeting on 23 July**	RECOMMENDED FOR CLOSURE

Report Title	Chair's Report
Author	Martin Havenhand, Chair
Accountable Director	Martin Havenhand, Chair
Previous committees/groups	N/A
Recommended action(s) (assurance, approval, information)	Information/Assurance
Purpose of the paper	To brief Board members of the activity and stakeholder engagement undertaken by the Chair and Non-Executive Directors (NEDs) since the last report presented to the Board in Public on 21 May 2026.

Executive Summary

This report provides the Board with an overview of activity undertaken by the Chair and Non-Executive Directors since the May 2026 Board meeting.

Key areas include completion of the Chair and NED appraisal process and agreement of 2026/27 objectives; the appointment of Michael Wright as Non-Executive Director and Chair of the Finance and Performance Committee; and continued engagement with staff, leaders, partners and stakeholders across the Trust and wider health system.

The report highlights visits and engagement linked to operational delivery, leadership development, staff recognition, quality improvement, alternative urgent community-based pathways, and the YAS Admin Network.

It summarises additional NED and Associate NED activity, including committee development, staff network engagement, induction, site visits, community engagement and wider NHS learning.

These activities support the Board's oversight of culture, recruitment and retention, partnership working and service improvement.

Recommendation(s)	It is recommended that the Board note the report.
Link to Board Assurance Framework Risks (board and level 2 committees only)	6. Develop and sustain an open and positive workplace culture. 8. Deliver and sustain improvements in recruitment and retention. 10. Act as a collaborative, integral, and influential system partner.

Chair's Report

1.0 SUMMARY

1.1 This report provides an update of the Chair's and Non-Executive Directors (NED) activities since the last report presented to the Board of Directors in Public on 21 May 2026.

2.0 Chair and NED Appraisals

2.1 My appraisal for 2025/26 and those of my NED colleagues are complete, with objectives agreed for 2026/27. My documentation has been submitted to NHSE Region by the deadline of 30th June.

3.0 Appointment of Michael Wright, Non-Executive Director

3.1 I am delighted to welcome Michael to the Board. His skills and extensive experience, along with the strong alignment of his personal values with YAS values, will be extremely beneficial to the Trust and we look forward to working with him. I would also like to formally thank Andrew Chang, who has stepped down after six years, for his significant contribution.

3.2 As a non-executive member of the YAS Board, Michael's role is to work alongside other Board colleagues to ensure the Trust has a clear strategy and plans to provide high quality, safe services to our patients and communities across the region. He will be Chairing our of the Finance and Performance Committee.

4.0 Visit from West Yorkshire Integrated Care Board (ICB)

4.1 On 26 May Peter Reading and I hosted a visit from Mark Chamberlain, Chair and Jonathan Webb, Interim Chief Executive of West Yorkshire ICB. During the visit, they toured our Emergency Operations and Integrated and Urgent Care call centres and took the opportunity to speak with colleagues about the services they deliver.

5.0 Long Service and Retirement Awards

5.1 On 2 June, I attended our Long Service and Retirement Awards ceremony at the Pavilions in Harrogate, which recognised staff for their exceptional contribution to YAS and the NHS throughout their careers.

5.2 Mrs Rebecca Cottrell, Deputy Lord Lieutenant of North Yorkshire, attended as the King's representative and joined me in presenting the awards. Dr Yvette Oade, Deputy Lord Lieutenant of West Yorkshire, also attended to present awards to our volunteers.

6.0 Senior Leadership Community

6.1 On 9 June, along with board colleagues I attended the Senior Leadership Community event at Wakefield Trinity RLFC. The agenda included several engaging sessions, including:

- Civility Saves Lives, delivered by Chris Turner, Consultant in Emergency Medicine at University Hospitals Coventry and Warwickshire and co-founder of the campaign, which highlights the impact of behaviour on performance.
- The Behavioural Framework and "See Something Wrong, Do Something Right" campaign, delivered by our Leadership and Development Team.
- Business plan priorities, including productivity, efficiency and improvement, presented by Marc Thomas, Deputy Chief Executive and Chief Operating Officer.
- A Quality Improvement session focused on sickness absence.

7.0 Visit to our 999 Call Centre in York

7.1 On 10 June I had the opportunity to meet with colleagues in York and discuss the implementation of NHS Pathways and the training and support had been received. I was pleased to hear the positive approach that staff had taken to the changes and that they believe it is a real improvement for patients.

8.0 Association of Ambulance Chief Executives (AACE) Council and AACE Chairs Meetings

8.1 On 17 June and 1 July I attended these AACE meetings. A key issue was the work that our AACE colleagues have been undertaking with our own teams about how we are delivering 'Care Closer to Home'. There are some examples good practice which were shared.

9.0 West Yorkshire Chairs' Meeting

9.1 Mark Chamberlain, the new Chair of West Yorkshire ICB has reintroduced West Yorkshire Trust Chairs' Meetings and we met on 30 June. Tabitha Arulampalam is our lead NED for West Yorkshire and will be attending these meetings.

10.0 Visit to Clinical and Health Records

10.1 On 2 July I spent the morning visiting our Clinical Audit team in Sheffield and was impressed with the commitment of our colleagues in identifying learning opportunities and influencing improvements to our practice and delivery of our service.

11.0 West Yorkshire Community Provider Collaborative Board

11.1 On 7 July, I chaired this meeting of Chairs and Chief Executives providing community services across West Yorkshire, supported by Dave Green, Executive Director of Quality and Chief Paramedic. Marc Thomas our Deputy Chief Executive and Chief Operating Officer presented and led a discussion on 'maximising alternative urgent community-based pathways', including how Yorkshire Ambulance Service is developing this internally and working with partners to achieve the best possible outcomes for patients.

12.0 YAS Admin Network

12.1 On 8 July I had the pleasure of joining the first development session of the YAS Admin Network. The agenda included an overview of the network and its priorities, a focus on Microsoft Copilot and how this can support day to day tasks and details of resources and peer support. A great presentation was given by Carly Olley, Clinical Directorate Manager, who gave an overview of her career and how she's worked in a variety of administrative roles throughout her journey at YAS.

12.2 I was impressed by our admin colleagues' commitment to the work of the Trust and sharing good practice and exploring how they can add value in their different roles.

13.0 Visit to our new Hull Ambulance Station

13.1 On 16 July I met with Paul Mudd our Head of 999 operations and had a tour of the new ambulance station which is nearing completion. It is a very impressive building. The colleagues I spoke with were all very enthusiastic about the opportunity the new facility will provide by bringing services together under one roof which will have a positive impact on morale and colleague wellbeing.

14.0 NED and Associate NED Activity

14.1 In addition to their Trust Board and committee roles, NEDs have reported the following additional activities they have undertaken.

14.2 Amanda Moat

I have attended SY and WY Audit Committee Chairs network with a focus on sharing best practice.

Myself and executive colleagues have begun evaluating the amazing nominations for the upcoming stars awards. I am always impressed and inspired by the incredible stories.

Additional events I have attended and found both engaging and worthwhile for learning and listening to others' experiences, have been the senior leadership community event and the NHS Alliance Digital Boards event. There were some good next steps in each to advance ideas for innovation and improvement.

14.3 Saghir Alam

I was a member of the judging panel for the STARS Awards category Growing Together.

I have attended community events including Boston Castle Park 150 Years Celebration and The Yemeni Community Awards Event.

14.4 Melanie Hudson

I met with Andrew Chang the past Senior Independent Board Director to better understand his experiences in the role as part of his handover to me as I take up the role from 1st July 2026.This was followed by my attendance at a NHS Alliance Board Development session, with others across the country to better understand the role of the SID.

In my capacity as the Board Champion for the Women and Allies staff network I attended their recent meeting which was useful and included the work to prepare for the launch of some new initiatives, and how to support staff to feel confident to raise concerns.

On 9 June I attended the in person Senior Leadership Community event in Wakefield, which was also a great opportunity to meet, network and get to know some of the wider leadership team.

I have taken part in the shortlisting for one of the Trust's STARS Awards, which showcased the amazing teams we have working at YAS.

14.6 Tabitha Arulampalam

In May I went on an ambulance ride out which gave me good insight into front line work. Their commitment to the job, care to patients and their level of competence shown on the ride were impressive. Many issues came up which are now being followed through.

In June I attended the YAS Long Service Awards and the Senior Leadership Community away day which gave me the opportunity to listen to our leaders and learn about current good practice as well as challenges.

During June I visited stations in Wetherby, Seacroft, Leeds, Beverly, Hornsea and Hull. It was very encouraging to see the commitment from staff but also to understand the way they dealt with local challenges as well as challenges that YAS posed to their work. The new station in Hull is a wonderful example of how things can be improved and modernised, a model to follow.

I visited our Regional Operations Centre and heard about the regional and national links they have and how they respond across these areas.

In my capacity as the Board Champion for the Race Equality staff network I have attended the Racial Equality Network Steering Group and chaired People Committee.

14.7 Becky Malby

This month I have finished my induction meetings with the Executive team, the Quality Improvement team, and observed the People Committee.

To support my role as Chair of the Quality Committee I attended the Clinical Quality Development Forum, and a Schwartz Round.

I remain impressed at the organisational and staff commitment to learning and professional review.

I contributed as a speaker on the main stage at the NHS Confederation annual conference on the future of the NHS.

14.8 Rebecca Randell

I observed the West Yorkshire Community Health Services Provider Collaborative Quarterly Meeting, chaired by Martin Havenhand. Marc Thomas gave a presentation on 'Maximising alternative urgent community-based pathways' and presented interesting data on number of referrals from YAS to different services that were accepted/rejected. It was good to see positive engagement and support from meeting attendees for YAS's ambition to increase hear and treat and see and treat rates, but also to hear the questions that attendees raised.

15.0 Recommendation

15.1 It is recommended that the Board note the report.

Board of Directors (in Public)
23 July 2026

Report Title	Chief Executive's Report
Author	Peter Reading, Chief Executive
Accountable Director	Peter Reading, Chief Executive
Previous committees/groups	None
Recommended action(s)	Information/ Assurance
Purpose of the paper	To brief Board members on some important matters for the Trust, some of which may be covered in more detail elsewhere in the Public or Private meetings of the Board.

Executive Summary

The Chief Executive's Report provides Board members with a briefing on key developments, achievements, and challenges across Yorkshire Ambulance Service (YAS) during the recent period.

- National Oversight Framework Quarter 4
- Advanced Foundation Trust Programme
- Celebrating International Paramedics Day
- Celebrating 20 years of Caring for Patients across the Region
- Staff and Volunteer Long Service Awards
- Celebrating Volunteers
- New Deputy Medical Director
- Restart A Heart Award
- Hosting NHS Alliance Visit
- Thirsk Ambulance Station
- Plans for a New Ambulance Station in Sheffield
- Non-Executive Board Changes

Recommendation(s)	To note the update from the Chief Executive
Link to Board Assurance Framework Risks (board and level 2 committees only)	1. Deliver a timely response to patients. 6. Develop and sustain an open and positive workplace culture. 9. Develop and sustain improvements in leadership and staff training and development.

Chief Executive's Report

1. SUMMARY

1.1 This paper briefs Board members on some important matters for the Trust, some of which may be covered in more detail elsewhere in the Public or Private meetings of the Board. Board members are invited to discuss any of these items, as they choose, and to note them for information.

2. National Oversight Framework - Quarter 4

2.1 YAS has been placed first amongst the ten English ambulance trusts in the National Oversight Framework Quarter 4 Ambulance Sector League Table published last month (June), moving from second position in quarter 3. The ranking reflects the hard work and dedication of our staff.

2.2 Although we are pleased with this latest ranking, we know that there are still areas for improvement, particularly in other some areas measured by the framework, such as conveyance of patients to emergency departments and staff sickness rates – and these are two of our three key Business Plan objectives for 2026-27. Also, the new additional national oversight framework metrics for 2026-27 will include more areas to focus on, so there is more for us to do.

3. Advanced Foundation Trust Programme

3.1 Yorkshire Ambulance Service will be one of the second wave of applicants to be assessed for Advanced Foundation Trust status by NHS England. This is in recognition of our demonstration of consistent high performance during 2025-26 and being placed in segment 1 of the NHS Oversight Framework for each quarter last year.

3.2 Securing advanced foundation trust status will require successful assessment as part of the Advanced Foundation Trust Programme and we will need to demonstrate how we meet the assessment criteria. Successfully passing the assessment will enable us to benefit from a more streamlined and strategic approach to annual planning, a capability-based approach to oversight and targeted financial flexibilities allowing us to direct surpluses from day-to-day spending towards future capital projects.

3.3 These freedoms will support us to make decisions locally to improve services for patients across Yorkshire and continue to work with partners to improve the health of the communities we serve.

4. Celebrating International Paramedics Day

4.1 We celebrated International Paramedics Day on 8 July by recognising the vital contribution of paramedics and frontline colleagues across Yorkshire and the Humber.

4.2 This year's theme, 'Innovate and Integrate', highlighted how paramedics are helping to transform urgent and emergency care for patients, through advanced clinical skills, remote assessment, digital technology, research and closer working with healthcare partners.

4.3 In 2025-26, we had 2,266 paramedics who worked alongside colleagues to respond to around 909,000 emergency incidents, either on scene or through telephone advice.

4.4 Today, paramedics are working in a wide range of roles, including emergency response, NHS 111, Emergency Operations Centres, urgent care, mental health pathways, critical care, specialist services and research. This video gives you a flavour of some of the research projects our paramedics are involved in.

4.5 Their expertise is helping more patients receive the right care sooner, while ensuring emergency resources remain available for those with the most serious and life-threatening needs.

5. Celebrating 20 years of caring for patients across the region

5.1 YAS also celebrated two decades of providing emergency, urgent and non-emergency healthcare services to millions of people across Yorkshire and the Humber. The Trust was formed on 1 July 2006 following the merger of South Yorkshire Ambulance Service, West Yorkshire Metropolitan Ambulance Service and the North and East Yorkshire parts of Tees, East and North Yorkshire Ambulance Service.

5.2 Since 2006-07, the Trust's workforce has more than doubled, rising by around 113% from 3,600 to 7,700 full and part-time staff, while annual '999' calls have increased by around 130%, from 544,000 to 1.25 million in the last year.

5.3 Staff and volunteers have responded to changing patient needs, rising demand and major developments in healthcare, technology and clinical practice, while continuing to provide compassionate care to people when they need it most. Since its formation, YAS has dealt with more than 18 million '999' calls, carried out almost 20 million non-emergency journeys and answered over 21 million NHS 111 calls.

5.4 To mark the anniversary, we shared memories from over the years with details on our website.

6. Staff and volunteer long service awards

6.1 YAS celebrated the achievements and dedication of its staff and volunteers at its annual Long Service Awards event in June. At the ceremony, the Trust recognised the commitment of 190 members of staff and 68 volunteers with a combined total of over 5,000 years of service.

6.2 80 staff were in attendance and were presented with their long service award for 20, 30, 40 or 50 years in the NHS, as well as King's and Queen's Long Service and Good Conduct Medals, given to colleagues with 20 years' exemplary frontline emergency service. The awards were presented by the Deputy Lieutenants for North and West Yorkshire. Awardees

included 14 colleagues who have reached a remarkable 40 years' service and one colleague who has completed 50 years' service before retiring.

6.3 This year, thanks to funding from the Yorkshire Ambulance Service Charity, long-serving YAS volunteers were able to join the annual event for the first time. YAS has approximately 1,000 volunteers giving their own time. The event recognised 68 volunteers who have given a total of 717 years of service.

6.4 The event is a great opportunity to recognise the incredible hard work and dedication of our colleagues, both staff and volunteers and to thank them for their many years of service to patients, local communities and colleagues across the region.

7. Celebrating volunteers

7.1 During Volunteers' Week at the start of June, we recognised, celebrated and thanked our volunteers for the remarkable contribution they make across Yorkshire every day. Volunteers play a vital role within the organisation, giving their time, compassion and skills to help us provide safe, effective and patient-centred care.

7.2 During 2025, nearly 1,000 volunteers gave almost 290,000 hours to support 58,782 patients and communities in a range of roles, as community first responders, Patient Transport Service car drivers, as members of our Critical Friends Network and most recently as community engagement volunteers across Yorkshire and the Humber.

7.3 This year has seen substantial progress with our volunteering initiatives. It has been three years since we launched our first Volunteer Development Framework which sets out our commitment to supporting and enhancing volunteering, and we have shared a summary of what we have achieved so far.

8. New Deputy Medical Director

8.1 We welcomed Dr Dave Kirby as its new Deputy Medical Director at the start of June. After qualifying as a doctor 20 years ago, Dave has worked in primary care for 15 years, the majority of which have been in medical leadership roles.

8.2 Most recently he has worked in YAS's Emergency Operation Centre for the last two years, helping to review 999 calls, ensuring that patients receive the most appropriate response, as well as providing clinical support to ambulance colleagues. Dave's experience of community and primary care will be invaluable in helping the Trust to develop services for patients and communities.

9. Restart a Heart award

9.1 Restart-a-Heart Day initiative has scooped the Kate Granger Outstanding Contribution Award at the 2026 Yorkshire Choice Awards which celebrated the people, businesses, charities and organisations making a real difference across Yorkshire.

9.2 Since 2014, Restart a Heart Day has delivered lifesaving CPR training to more than 311,000 young people across Yorkshire secondary schools, equipping them with the skills and confidence to save a life through CPR and the use of a defibrillator. Delivered entirely by the Trust's staff, volunteers and partners who give their time freely each year, the campaign has become a powerful example of community action and public service and it has helped increase Yorkshire's bystander CPR rates by 35%, saving countless lives.

9.3 Volunteers can still sign up to teach CPR on our 13th annual Restart a Heart Day on Friday 16 October 2026 by emailing yas.restartaheart@nhs.net and more information is available on our Restart a Heart website.

10. Hosting NHS Alliance visit

10.1 Senior representatives from The NHS Alliance – a new organisation formed from the merger between NHS Providers and the NHS Confederation to represent and support the health and care system in England, Wales and Northern Ireland – visited YAS in Hull this month.

10.2 Sir Ciarán Devane, Chief Executive, and Matthew Hopkins, Acute and Ambulance Network Consultant, met with YAS senior managers to hear about the range of challenges and opportunities currently facing YAS and the ambulance sector. They also received an update from Ruth Crabtree, our Public Health Lead and National Lead for Public Health, Association of Ambulance Chief Executives (AACE), who talked about the pioneering public health work she is involved in. We were also able to give an overview of developments with our estates and vehicles and provided a tour of the facilities at the new Hull Ambulance Station.

11. Thirsk Ambulance Station

11.1 The new ambulance station at Thirsk is now up and running, with significant improvements made to welfare facilities and staff areas. These include a new mess room, training room, meeting room facilities, changing room and showers.

11.2 The site also has an environmentally friendly design, with solar panels, an air source heat pump, air conditioning and energy efficient lighting. The station is operating at carbon neutral, supporting the Trust's transition to renewable energy.

12. Plans for a new ambulance station in Sheffield

12.1 The Trust is developing plans for a new, modern ambulance station in Sheffield to replace the current estate, which is no longer suitable for the scale and needs of the local workforce. The proposed station would bring together teams currently based across three Sheffield ambulance stations, alongside key operational functions including 999 Operations, Patient Transport Service, Ambulance Vehicle Preparation, fleet workshop facilities and dedicated training space. The aim is to improve the availability, readiness and efficiency of the ambulance resources serving Sheffield and South Yorkshire.

12.2 A key benefit of the proposal is the opportunity to improve patient response times by reducing the time ambulances are unavailable between incidents. Ambulance Vehicle Preparation would allow vehicles to be cleaned, restocked and refuelled more efficiently, while an on-site fleet workshop would reduce the need for vehicles to be moved elsewhere for maintenance. Together, these changes would help increase ambulance availability and release more clinical time for patient care. Independent modelling indicates that, alongside the continued use of standby points across Sheffield and dynamic deployment of resources, the proposal could improve mean response times in South Yorkshire by 25 seconds for Category 1 incidents and by 2 minutes and 27 seconds for Category 2 incidents.

12.3 The new station would also deliver significant improvements for staff welfare. Current sites face challenges including overcrowding, limited parking, ageing buildings, and unsuitable rest, changing and training facilities. A purpose-built station would provide safer, more modern facilities for staff at the start and end of shifts and during rest breaks, while dedicated training space would support local learning and development and reduce the need for staff to travel. These improvements are expected to support recruitment, retention and day-to-day working conditions for colleagues based in Sheffield.

12.4 The business case is still being developed, and the Trust has updated partners including Sheffield City Council's Scrutiny of Health Committee and MPs and will continue to engage with staff, partners, elected representatives and local stakeholders before any final decisions are made. More information is available on our website.

13. Non-Executive board changes

13.1 Our board meeting on 25 June 2026 was the final meeting for our Non-Executive Director (NED) and Senior Independent Director, Andrew Chang, whose six-year term came to an end. The Board recognised Andrew's significant contribution to YAS and wished him well for the future. Michael Wright has now joined the Board as a NED, and his appointment runs from 1 July 2026 until 30 June 2029. More information about the Board of Directors is available on our website.

14. RECOMMENDATION

14.1 It is recommended that the Board:

- Note the Chief Executive's Report

Trust Board (In Private)
23 July 2026

Report Title	Chief Executives Report – Chief Executive and Director Objectives 2027-2027
Author	Peter Reading
Accountable Director	Peter Reading
Previous committees/groups	N/A
Recommended action(s) (assurance, approval, information)	Information
Purpose of the paper	To share the objectives set for the Chief Executive and Executive Directors for 2026-2027 with the Trust Board.

Executive Summary

Chief Executive and Executive Director Objectives for 2026-2027, are attached for information.

Recommendation(s)	To note the objectives set for 2026-2027.
Link to Board Assurance Framework Risks (board and level 2 committees only)	All Areas.

CHIEF EXECUTIVE AND DIRECTOR OBJECTIVES 2026-2027

PETER READING – CHIEF EXECUTIVE

Objective 1 – Drive the Trust to deliver its 2026-27 Annual Business Plan, focusing most on the Plan's Three Priorities

- Priority 1 - Right response. Increase Hear and Treat from 13.4% (2025-26 mean) to 15.4% and reduce Emergency Department conveyance by 1.3% from 52.8% (2025-26 mean).
- Priority 2 - Improve operational productivity and performance. Deliver Category 2 response time of 24:44 in 2026/27 while reducing unwarranted variation by time of day and geography.
- Priority 3 - Support our people. Reduce Trust-wide sickness absence by 0.5% through prevention, proactive wellbeing, and support.

Objective 2 – Drive further strengthening of the leadership of YAS

- Agree actions with Board following the AQUA Well Led Review and oversee implementation of these.
- Focus executive team on strengthening senior and middle level leadership, including in Digital, Quality Governance and Operations.
- Focus executive team on strengthening junior (Bands 8A and 7) leadership in Operations.
- Link these focuses on strengthening leadership at all levels to enhancing partnership working and supporting delivery of the national Ten Year Plan objectives.

Objective 3 – Deliver responsibilities as Accountable Officer

- Support delivery of 2026-27 Annual Financial Plan, with focus on cost and productivity improvements and reducing structural deficit.
- Drive delivery of Annual Business Plan, focusing both on the Three Priorities and the key enablers (including Digital, Estates, Fleet, etc.).

Objective 4 – Focus on staff engagement and wellbeing

- Actively engage in supporting delivery of Business Plan Priority 3 (see above).
- Support review of and improvements in ways in which staff are engaged, including - continued strong focus on learning from and engaging staff in National Staff Survey; working with trades unions to make their engagement in the management of YAS more appropriate and more in line with the rest of the NHS; and support establishment of an effective 'Shadow Board'.

Objective 5 – National and regional roles and engagement

- Continued active engagement in AACE, NHS England and NHS Employers Policy Board, promoting the role and/or of the ambulance sector and/or YAS, as appropriate.
- Continued role as Co-Chair of National Ambulance Social Partnership Forum.

Objective 6 – Equality, Diversity & Inclusion

- Supporting development and implementation of a YAS Health Inequalities Improvement Plan.
- Continuing to be active as Board Sponsor of YAS Racial Equality Network.
- Continuing (in role of Co-Chair of Disabled NHS Directors Network) to work closely with NHS Alliance (NHS Employers) to establish a national Disabled Staff Network.
- Continuing to be personally involved in driving all aspects of the EDI agenda at YAS and where appropriate, nationally.
- Continuing active membership of NHS England EDI Board.

MARC THOMAS – DEPUTY CHIEF EXECUTIVE & CHIEF OPERATING OFFICE

Objective 1 – Reduce variation in performance across the day by March 2027

- Develop demand profile and agree main areas of mismatch between demand and supply
- Establish principles for rota reform (alongside changes to annual leave and flexible working as required)
- Support operational leaders to implement

Objective 2 – Develop operational management culture

- Develop arrangements for revised structure by end June
- Undertake development programme with team
- Work with operational leaders to clarify expectations at each level

Objective 3 – Embed culture of remote care first

- Adapt strategy to reflect new approach by end September
- Ensure consistent comms

Objective 4 – Support the development of system-wide approach to urgent care

- Agree priority areas for the development of alternatives by end June
- Influence ELB to recognize importance of a coordinated approach and enable system leaders to support
- Increase use of alternatives by at least 10% by end March 2027

Objective 5 – Deliver overall operational plan and productivity enhancements

- Working through ACOOs and cross-cutting delivery groups (e.g. workforce planning) to deliver agreed activity and staffing levels, and improvements in productivity e.g. reduce crew clear.

Objective 6 – Equality, Diversity and Inclusion

- Exec-level champion for reciprocal mentoring
- Continue to be Board Sponsor for the Disabled Staff Network

KATHRYN VAUSE – EXECUTIVE DIRECTOR OF FINANCE

Objective 1 – Deliver financial sustainability and improved productivity

- By 31 March 2027, deliver the Trust's agreed financial plan and year-end financial position, while ensuring that savings plans are fully identified, and monitored monthly. Whilst the submitted 3-year plan maintains a modest underlying recurrent deficit, direct financial decisions such that this is improved upon.

Objective 2 – Provide strategic executive leadership for the Trust's Net Zero agenda

- By 31 March 2027, lead on the delivery of the annual milestones in the Trust's Green Plan and ensure sustainability is embedded in 100% of relevant business cases, capital schemes, and major investment decisions. Establish appropriate reporting through the Trust's governance structures, including to Board.

Objective 3 – Strengthen governance, assurance and executive leadership across the portfolio

- By 31 March 2027, maintain / strengthen as necessary effective board and committee oversight across finance, net zero, fleet, estates and facilities, contracting, and procurement through timely reporting, clear risk management, and delivery monitoring.

Objective 4 – Visible executive leadership across the Trust

- By 31 March 2027, demonstrate a consistent and visible executive leadership presence across the Trust, engaging regularly with frontline and corporate teams, communicating clearly on strategic and financial priorities, and championing organisational values, inclusion, and wellbeing. Actively contribute to cross-Trust leadership and culture, supporting delivery of corporate priorities and development of a high-performing, inclusive leadership environment.

Objective 5 – Equality, Diversity and Inclusion

- To actively champion equality, diversity and inclusion through my role as Executive Lead for the Women's Network and through my involvement in women in leadership across NHS Finance, while also supporting a broader culture of inclusion that recognises and values all forms of diversity. I will provide visible executive sponsorship, promote opportunities for women to connect, develop and influence, and use my leadership role to help remove barriers to progression. I will also seek to understand and advocate for the experiences of colleagues from different backgrounds, including in relation to race, disability, sexual orientation, gender identity, age, religion or belief, caring responsibilities and socio-economic background.

DAVE GREEN – EXECUTIVE DIRECTOR OF QUALITY & CHIEF PARAMEDIC

Objective 1 – Continue to promote and help to evolve the paramedic profession from Trust and national perspective

- Work at Trust level to promote the paramedic workforce in terms of continuing development in clinical care.
- Support the development of Specialist Paramedic practice.
- Continue to support the development of the profession in national forums: Royal College of Paramedics, AACE Chief Paramedic Group and NHSE Chief Paramedic Group.
- Engage with the local Heads of Paramedic programmes from the local universities periodically, alongside the ongoing YAS Academy relationship meetings.

Objective 2 – Patient Experience – Enhancing Patient Experience Feedback

- Strengthening feedback mechanisms to ensure patient voices - including those currently under-represented - inform improvement, shape service design, and support personalised, equitable care. This priority aligns with the NHS Long Term Plan, CORE20PLUS5, and national Experience of Care frameworks.
- Increase the number of patient survey responses by 10%
- Undertake three deep dive dives into patient experience (Maternity, COPD and Impact of volunteers)

Objective 3 – Continue to reduce Patient Complaint handling times

- Continue the introduction of local resolution supported by the service lines, so that when a complaint is received it can be resolved quickly.
- Reduction in the time it takes to respond to a formal complaint by identifying bottle necks and improving the process. The target is a reduction of 10% with a 20% internal stretch target.

Objective 4 – Continue to evolve Quality Improvement across the Trust

- Embed and sustain Quality Improvement as the Trust's core approach to improvement with clear senior leadership sponsorship, and measurable impact.
- Embed Quality Improvement as the Trust's improvement approach to delivering strategic priorities, with clear delivery.
- Embed and operate a sustainable QI business partnership model that enables corporate and operational teams to lead and sustain improvement with measurable impact.
- Establish and utilise a YAS Innovation and Improvement Hub to support local collaboration, learning, innovation and the spread of improvement at scale.
- Progress the early development of a coherent Trust-wide Quality Management System (QMS) that tightens quality assurance, strengthens alignment between improvement and assurance activity, and supports CQC readiness and quality management.

Objective 5 – Clinical Effectiveness – Implementation of the Clinical Response Model

- Deliver the next phase of the CRM to improve clinical decision-making, reduce unwarranted variation, and strengthen integration between remote and operational clinical teams. This work is aligned to national advanced practice standards and Trust-approved CRM design principles.
- Recognition of Critical Care as a Trust wide asset and transfer to Special Ops – completed.
- Urgent Care review with recommendations for future delivery model – in progress.
- Mapping Specialist and Advanced Practice across YAS via the NHSE Maturity Matrix and create a YAS Advanced Practice Framework – in progress.
- Regional pathways leads / review – in progress.
- Crew line governance to be strengthened through bringing it under EOC – in progress.

Objective 6 - Clinical Supervision

- Deliver the final year of the clinical supervision implementation programme, with a focus on improving access for the generalist workforce and embedding supervision within routine practice.
- Implement a QR code–enabled access model to facilitate timely supervision for high-priority cases.
- Maintain sufficient numbers of trained restorative supervision facilitators to meet demand.
- Scope options to enhance sustainability of YAS Clinical Supervision offer through development of in-house courses which support professional advocacy development.
- Ensure all investment days incorporate structured supervision, subject to TBW review outcomes.
- Explore digital innovation for delivery that links data systems (patient outcome dashboard, portfolios).

Objective 7 - Support the Trust EDI agenda as a senior leader

- Engage with the Community Engagement Team to offer any support for any events reaching out into multi-cultural communities to promote the paramedic profession.
- Continue to support the Armed Forces Support Network as Executive sponsor.
- Continue to participate in reciprocal mentoring.

SHONA MCCALLUM – EXECUTIVE MEDICAL DIRECTOR

Objective 1 – Embed learning from deaths, morbidity and mortality meetings and demonstrate organisational learning

- Lead on the 360 internal audit, LFD Policy, governance arrangements and podcasts for staff

Objective 2 – Develop the Quality Governance assurance meeting to provide assurance on completion of actions (including peer to peer review)

- Oversee the Datix process, review the output of the meeting to ensure it remains relevant. Further review the potential inclusion of audit action completeness and LfD actions

Objective 3 – Embed the Infection Prevention and Control (IPC) BAF and develop a workplan to meet the needs of the YAS workforce

- Focus on: Staff compliance with PPE; Needlestick injuries; Hand hygiene audits; Estates and facilities; Flu and immunisation.

Objective 4 – Continue to develop system relationships to develop alternative pathways to conveyance

- Present at the clinical leads network
- Introduce the role of a Clinical Director in RPC
- Review the ICB Quality Oversight meeting

Objective 5 – Embed the Clinical Quality Directorate

- Arrange an away day
- Develop the SLT and SMT meetings

Objective 6 – Develop a forward plan on health inequalities with a focus on mental health

- Scope the requirements to become a trauma informed organisation

MANDY WILCOCK – DIRECTOR OF PEOPLE & ORGANISATIONAL DEVELOPMENT

Objective 1 – YAS Together

Care Together

- Health and Wellbeing absence reduction plan
- Violence prevention/reduction

Lead Together

- Flexible working
- Team-based working

Grow Together

- Inclusive talent development
- Appraisal and career conversation

Excel Together

- Quality improvement-led organisation

Everyone Together

- Behavioural framework call to action: “See something wrong, do something right”
- Inclusive recruitment review

Objective 2 – Health and Wellbeing

- Research and deliver an immunisation programme including a pilot across all YAS Academy sites by March 2027.
- Develop a needs-driven business proposal with a clear vision for the provision of Occupational Health Services by March 2027.
- Collaborate with Health & Safety colleagues to improve Musculoskeletal (MSK) injury awareness at Trust level and implement interventions to reduce harm.
- Business Priority – Reduce sickness absence (detailed workstreams to be defined following completion of the comprehensive data analysis and focus groups).

Objective 3 – Equality, Diversity and Inclusion Objectives

Inclusive Recruitment & Selection

- Phase 2: Review application and shortlisting stage to ensure support for those coming in and progressing through YAS. Partners: People Services.
- Re-scope Phase 3 (Interview and selection) and Phase 4 (Outcome and Offer). Partners: People Services.
- Improve representation of application numbers and subsequent appointments to aim to reflect the communities we serve. Partners: Community Engagement, People Services and YAS Academy.

Inclusive & Compassionate Culture

- Use available data on bullying, harassment and abuse to identify themes and where a focused Culture Development Approach may be needed to work collaboratively to make improvements. Partners: Leadership & OD, FTSU and YAS Together.
- Develop and launch an Active Bystander to Upstander Programme to build on Allyship for all protected characteristics. Partners: Leadership & OD and Communications.

Staff Voice & Engagement

- Publish Anti-Racism Charter and supporting resources. Partners: Equality Support Networks and Communications.

- Commit to the AACE Neurodiversity Pledge, including co-design of a Neurodiversity Pledge Plan with representative stakeholders. Partners: Equality Support Networks and Enabling Staff Working Group.
- Identify and work towards a suitable framework to ensure YAS is a LGBT+ friendly workplace (for example Rainbow accreditation or Equality, Diversity and Inclusion). Partner: Equality Support Networks.
- Co-develop a Women in Operational Leadership Plan using the AACE Toolkit and Key Performance Indicators, informed by the YAS data trends. Partner: Equality Support Networks.

Objective 4 – Alignment with Strategy Priority 3 – Support our People, Reduce Sickness

- Target: 0.5% reduction in sickness absence by the end of 2026/27.
- The Prevention and Alternatives to Sickness Absence by strengthening alternative duties, enhancing workplace adjustments and optimising compassionate absence conversations directly supports this strategic priority 3 – Support Our People, Reduce Sickness by strengthening the quality, consistency, and effectiveness of sickness absence management. By enabling managers to act early and confidently, supported by clear standards, processes, and pathways, the workstream addresses key drivers of avoidable and prolonged absence.
- Contribution of Associated Projects
- Compassionate Absence Conversations:
- Alignment: Equips managers to hold consistent, supportive, and effective conversations with staff at the first point of contact and throughout absence. Early, compassionate intervention reduces escalation into prolonged absence.
- Impact on target: By intervening early, fewer absences become long-term, contributing to the 0.5% reduction in sickness.
- Alternative Duties Framework:
- Alignment: Provides temporary redeployment options for staff unable to perform their substantive role, maintaining engagement and productivity while supporting recovery.
- Impact on target: Minimises absence days and prevents avoidable loss of capacity, directly supporting the reduction target.
- Workplace Adjustments:
- Alignment: Ensures staff have appropriate changes to environment, equipment, policies, or role expectations, reducing barriers to attendance.
- Impact on target: Supporting staff to remain at work or return sooner reduces preventable absence, contributing to the 0.5% reduction goal.

Objective 5 – Readiness for the new Target Operating Model (TOM)

- Work with colleagues from NHSE National and Regional Teams on preparation for the new TOM for people services. This includes preparation for the implementation of the Future Workforce System which will replace the Electronic Staff record (ESR). This will include implementation of manager self service and data cleansing.

SAM ROBINSON – CHIEF DIGITAL INFORMATION OFFICER

Objective 1 – Deliver the DDAT Strategy and Operating Model

- Publish and deliver the full DDAT Strategy and transition to a proactive benefits-led operating model

Objective 2 – Improve Operational Performance through Digital Enablement

- Deliver digital solutions that improve productivity and patient flow

Objective 3 – Establish a Resilient, Secure and Scalable Digital Foundation

- Deliver infrastructure and cyber improvements

Objective 4 – Embed Service Management Excellence

- Deliver ITIL-aligned service management
- Key Outcomes: - Service ownership model; - Improved incident handling; - Better user experience

Objective 5 – Deliver a Trust-wide Date and BI capability

- Establish data and BI capability for decision-making
- Key Outcomes: - BI strategy delivered; - Single version of truth; - Self-service analytics; - Insights delivered over data

Objective 6 – Build Digital Capability, Leadership and Culture Objective

- Develop workforce capability and leadership
- Key Outcomes: - Digital literacy delivered; - Leadership strengthened

Objective 7 – Equality, Diversity and Inclusion

- Champion equality, diversity and inclusion within DDaT by ensuring our workforce, technology and services are accessible, inclusive and informed by the diverse needs of the colleagues and communities we serve.

Key Outcomes

- Inclusive recruitment and talent development practices embedded.
- Accessibility-by-design approach adopted for new digital services.
- EDI considerations evidenced within governance and investment decisions.
- Positive contribution to Trust EDI objectives and culture improvement.

CAROL WEIR – DIRECTOR OF STRATEGY, PLANNING AND PERFORMANCE

Objective 1 — Lead and assure delivery of the Strategy, Planning and Performance (Golden Thread)

- By 31 March 2027, lead and assure the continued development of the Trust's golden thread from Trust Strategy → Five-Year Plan → Annual Business Plan → Performance Management, ensuring YAS' strategic vision of remote care first, the Clinical Response Model, left shift and one connected out-of-hospital system is clearly reflected in in strategic priorities, planning, delivery, investment decisions and performance reporting.

- This includes reviewing progress against the Trust Strategy, identifying areas for re-emphasis in the changing national and regional context, maintaining internal and external engagement, leading the 2027/28 annual planning process, strengthening planning governance, and improving the quality and alignment of business cases and investment planning.

Objective 2 — Strengthen performance management and productivity delivery

- By 31 March 2027, strengthen the Trust's performance management approach so that delivery of the 2026/27 Business Plan priorities is actively monitored, challenged and supported, with a specific focus on operational performance, productivity, efficiency, improvement actions and delivery of agreed trajectories.

Objective 3 — Strengthen annual and long-term workforce planning

- By 31 March 2027, lead the continued development of annual and long-term workforce planning arrangements, ensuring workforce assumptions, trajectories and risks are clearly aligned to demand, finance, productivity, the Clinical Response Model, operational delivery and the Five-Year Plan.

Objective 4 — Drive system planning and collaboration to enable left shift, alternative pathways and strategic commissioning

- By 31 March 2027, lead and support YAS' contribution to system planning and strategic commissioning discussions, ensuring the Trust is positioned as a key clinical and system partner in delivering left shift, remote care, alternative pathways, reduced avoidable conveyance and improved urgent and emergency care performance.

Board of Directors (in Public)
23 July 2026

Report Title	Business Plan 2026/27 – Q1 Performance and Assurance Report
Author	Gavin Austin, Head of Performance and Improvement Carol Weir, Director of Strategy, Planning and Performance
Accountable Director	Marc Thomas, Deputy Chief Executive and Chief Operating Officer
Previous committees/groups	Trust Executive Group (15 July 2026) Finance and Performance Committee (16 July 2026) People Committee (1 September 2026) Quality Committee (10 September 2026)
Recommended action(s) (assurance, approval, information)	Assurance
Purpose of the paper	This paper provides Q1 assurance on delivery of the Trust's 2026/27 Business Plan, including the extent to which planned benefits were achieved and the impact on our three strategic priorities.

Executive Summary

This paper provides Q1 assurance on delivery of the 2026/27 Business Plan, including the extent to which planned benefits were achieved and the impact on our three strategic priorities.

Delivery of the 2026/27 Business Plan is progressing, although most workstreams remain in the mobilisation, design or early implementation phases. Of the 17 workstreams, the majority are rated Amber or Amber/Green, with one Red and one Amber/Red workstream requiring focused management attention. Overall, benefits realisation remains limited at Q1, with the majority of planned improvements expected later in 2026/27.

Strategic Priority 1 – Right Response has demonstrated encouraging progress. Hear and Treat improved to 14.0% in June, while ED conveyance reduced to 51.8%, indicating movement in the right direction despite performance remaining short of year-end ambitions. Supporting programmes, including Specialist Paramedic Urgent Care (SPUC)/Specialist Paramedic Mental Health (SPMH) utilisation, Common CAD, iCAS Phase 2 and alternative care pathways, are progressing largely within tolerance and are establishing the foundations needed to improve clinical decision-making, pathway utilisation and patient outcomes. Call handling in 999 operations has been challenging with performance below trajectory and, while current workforce levels are ahead of plan, recruitment of call handlers is behind plan and will lead to lower workforce numbers later in the year unless addressed. Overall, there remains confidence that the priority is on track to support longer-term improvements

Strategic Priority 2 – Operational Productivity and Performance presents the most challenging position. Category 2 response times deteriorated during June and were 1 minute 39 seconds slower than trajectory, while Crew Clear performance remains significantly above plan and did not achieve its ambitious Q1 trajectory. Although a range of improvement programmes are progressing, including Crew Clear, Crew Line Improvement, HCP Transport Reduction and Telematics, many remain in discovery, modelling or approval phases, limiting benefits realisation to date. Resource Alignment remains Red however there were no planned performance benefits in year with the workstream being multi year due to the time needed to develop plans and negotiate solutions that will be complex and sensitive so will not impact on performance targets in 26/27. Crew Clear is Amber/Red, requiring accelerated delivery and implementation during Q2.

Strategic Priority 3 – Support Our People remains a key area of focus. Sickness absence increased to 7.7% in June, remaining 1.2 percentage points above plan, with both long-term and short-term sickness continuing to place pressure on workforce availability. Progress has been made across the Preventative and Recovery Pathway, Alternative Duties Framework and Workplace Adjustments programmes, although all remain rated Amber largely due to governance and implementation delays rather than significant delivery concerns. These initiatives are strengthening the foundations for improved workforce wellbeing, attendance and productivity but are not expected to deliver significant measurable reductions in sickness during 2026/27.

Overall, the Board can take assurance that delivery is progressing broadly as expected for this stage of the year. However, benefits realisation remains dependent on accelerated mobilisation, completion of governance processes, resolution of programme dependencies and successful transition from planning into implementation during Q2. Key risks include 999 call handling performance, continued under performance against Crew Clear, progression of plans to align resource to demand and sickness absence trajectories.

Recommendation(s)	It is recommended that the Trust Board: 1. notes the Q1 delivery position against the 2026/27 Business Plan, including the current RAG+ ratings across the 17 workstreams. 2. takes assurance that delivery is broadly progressing as expected for this stage of the year, with the majority of workstreams within tolerance and governance, delivery and implementation arrangements continuing to develop. 3. notes that benefits realisation remains limited at Q1, with many workstreams still in mobilisation, discovery, design or early implementation phases, and that delivery confidence is dependent on accelerated implementation during Q2. 4. notes the key risks set out in section 4, particularly Category 2 performance, Crew Clear, 999 call handling capacity, EHA recruitment, resource-to-demand alignment and sickness absence.
Link to Board Assurance Framework Risks (board and level 2 committees only)	1. Deliver a timely response to patients. 6. Develop and sustain an open and positive workplace culture. 7. Support staff health and well-being effectively. 10. Act as a collaborative, integral, and influential system partner. 12. Secure sufficient revenue resources and use them wisely to ensure value for money. 13. Secure sufficient capital resources and use them wisely to ensure value for money.

BUSINESS PLAN 2026/27 – Q1
PERFORMANCE AND ASSURANCE REPORT

1.0 INTRODUCTION

1.1 Delivery of the 2024-2029 Trust Strategy is through the Annual Business Plan year-on-year, which sets out the in-year priorities against the Trust's four ambitions: Our Patients, Our People, Our Partners, and Our Planet and Pounds. This report provides the Board with the Q1 position on delivery of the 2026/27 Business Plan.

2.0 BACKGROUND

2.1 The 2026/27 Annual Business Plan was aligned to the NHS England operating context, the Trust Strategy 2024-29, Integrated Care Board Joint Forward Plans and local Place priorities. Delivery is monitored through workstream milestones, metrics, RAG+ ratings and the established performance improvement process and assurance through Trust governance routes.

2.2 The Business Plan is reported quarterly through agreed governance structures to TEG, Committees and the Trust Board, aligned with the Board Assurance Framework to identify and control strategic risks. The data contained within the report is up to the end of June 2026.

2.3 The NHS Oversight Framework (NOF) was officially launched on 26 June 2025, following public consultation. It marked a significant reset in how NHS England assesses integrated care boards (ICBs), NHS trusts, and foundation trusts, introducing a more consistent and transparent approach to performance oversight and accountability. The framework sets out segmentation based on agreed metrics and provides the foundation for improvement support across the system, aligning with the priorities in the 2025/26 planning guidance and the 10-year health plan. The NOF sets out a suite of metrics (eg Category 2 response times, ED conveyance rates, NHS Staff Survey engagement, sickness absence, financial position) that directly link to operational and strategic priorities in trust business plans. The metrics used to calculate the NOF scores are embedded into monthly and quarterly performance reviews and reporting – see Appendix 3 for the latest NHS Oversight Framework Metrics table. The Trust achieved 1st place ranking among the 10 NHS ambulance services in England in the Quarter 4 NHS Oversight Framework assessment, reflecting strong overall performance across the nationally reported measures used by NHS England. This position was supported by high staff engagement and advocacy scores, strong patient safety culture indicators, better-than-average response times, and a stable financial position. The ranking provides external assurance that YAS is performing strongly relative to its peers while maintaining focus on areas requiring further improvement, including sickness absence and reducing emergency department conveyance.

2.4 The 2026/27 Annual Business Plan has three Board-agreed priorities: improving the right response by increasing Hear and Treat to 15.4% and reducing Emergency Department conveyance by 1.3%; improving operational productivity and performance including Category 2 response time to 24:44 while reducing variation across the day and geography (including crew clear); and, supporting our people by reducing sickness absence by 0.5% Trust-wide.

2.5 **2026/27 Q1 at a glance**

2.5.1 The Q1 Business Plan position for the 17 workstreams within the 3 priorities is as presented below by RAG+ rating (further detail outlined in Appendix 2).

RAG+ rating	M1 position	M2 position	M3/Q1 position
Green	3	1	1
Amber/Green	3	6	3
Amber	8	7	9
Amber/Red	0	1	1
Red	2	1	1
Paused / Closed	0	0	1
Nonreporting workstreams	1	1	1
TOTAL	17	17	17

NB: Amber/Green rating should not be of significant concern as this rating reflects that there are minor risks to delivery that may impact performance, or there is slight but recoverable slippage of tasks or benefits. In some cases, they may remain Amber Green this quarter if delivery of tasks and benefits extends into 26/27 so are not complete in year. Amber red and red are the main areas requiring focus.

2.5.2 Strengthened scrutiny of RAG+ rating, forecasts, delivery confidence, known risks and dependencies will be embedded in 2026/27 reporting.

STRATEGIC PRIORITY 1 - RIGHT RESPONSE: Increase Hear and Treat and reduce ED conveyance						
*YAS will increase **Hear and Treat** to 15.4%*						
Workstream Programmes		**Project & Support**		**Apr-26**	**May**	**June**
1.1	Expanding EOC clinical capacity - SPUC/SPMH utilisation	1.1.1	Expanding the Remote Clinical Hub	GREEN	GREEN	GREEN
		1.1.2	Achieving Clinical Recruitment	GREEN	AMBER/ GREEN	AMBER/ GREEN
		1.1.3	Expanding SPUC & SPMHT H&T Utilisation	AMBER	AMBER/ GREEN	AMBER/ GREEN
1.2	Optimising integration - clinical queue, iCAS Phase 2 and joint CAD	1.2.1	Implementing iCAS Phase 2 (Joint Clinical Queue)	AMBER	AMBER	AMBER
		1.2.2	Implementing Common CAD for 111	AMBER	AMBER	AMBER
		1.2.3	Preparing for PTS CAD Implementation (2027/28)	NOT STARTED – PLANNING STAGE	NOT STARTED – PLANNING STAGE	
1.3	Improving Access and availability of appropriate care pathways	1.3.1	Optimising Alternative Pathways - Push & On Scene	AMBER	AMBER/ GREEN	AMBER/ GREEN
1.4	Additional work not listed in priorities	1.4.1	Achieving EHA Recruitment	GREEN	AMBER	AMBER

STRATEGIC PRIORITY 2 - IMPROVE OPERATIONAL PRODUCTIVITY & PERFORMANCE: Improve performance including Category 2						
YAS will reduce Category 2 average response times to 00:24:44 and minimise variability across the day and geography through improving operational efficiencies						
Workstream Programmes		**Project & Support**		**Apr 26**	**May**	**Jun**
2.1	Improve alignment of resource to demand	2.1.1	Demand, Capacity and Performance Analysis	RED	RED	RED
		2.1.2	Flexible Working Arrangements			
		2.1.3	Rotas			

STRATEGIC PRIORITY 2 - IMPROVE OPERATIONAL PRODUCTIVITY & PERFORMANCE: Improve performance including Category 2					
YAS will reduce Category 2 average response times to 00:24:44 and minimise variability across the day and geography through improving operational efficiencies					
Workstream Programmes		**Project & Support**	**Apr 26**	**May**	**Jun**
	2.1.4	Scheduling Process (including overtime allocation and relief staff).			
	2.1.5	Fleet Alignment			
	2.1.6	New 999 Operations Rest Break Standard Operating Procedure.	AMBER/ GREEN	AMBER	AMBER
2.3	Improving turnaround (Crew Clear)		RED	AMBER/RED	AMBER/RED
2.4	Redirecting Inappropriate Healthcare Professional (HCP) Transportation Requests (09:00–16:00)		AMBER	AMBER	AMBER
2.5	Enhancing Crew Line		AMBER	AMBER/ GREEN	AMBER
2.6	Realising Telematics Benefits		AMBER/ GREEN	AMBER/ GREEN	AMBER

STRATEGIC PRIORITY 3: SUPPORT OUR PEOPLE: REDUCE SICKNESS				
Reduce sickness absence by 0.5%, create a healthier, more skilled & engaged workforce				
Workstream Programmes		**Apr 26**	**May**	**Jun**
3.1	Preventative and Recovery Pathway	AMBER	AMBER	AMBER
3.2	Strengthening Alternative Duties Framework Project Impact	AMBER	AMBER	AMBER
3.3	Enhancing Workplace Adjustments Project Impact	AMBER/ GREEN	AMBER/ GREEN	AMBER

3.0 WHAT? – DELIVERY AGAINST THE 2026/27 PLAN

3.1 STRATEGIC PRIORITY 1 – RIGHT RESPONSE

3.1.1 *Q1 position and why:*

Urgent and emergency care metrics showed signs of improvement during Q1. The Hear and Treat rate increased to 14.0% in June, although it remained marginally below target, with further improvements expected as additional clinicians complete training and become fully operational. The ED conveyance rate also improved during the quarter, reducing to 51.8% in June and performing better than the same period last year, supporting progress towards reducing avoidable hospital conveyance. Call handling performance has been challenging with demand seeing significant spikes on day further impacting performance although broadly in line with plans across the month. Call handler numbers are in line with plan in Q1, but recruitment is behind plan which may lead to numbers falling behind plan unless action is taken.

The supporting business plan workstreams are broadly progressing as planned, with the majority rated Amber/Green or Amber, reflecting good delivery progress alongside manageable risks and dependencies. Governance arrangements, delivery plans and project structures are largely established, with notable progress in expanding clinical capacity, implementing Common CAD, developing integrated clinical queue arrangements and enhancing alternative care pathways. While some projects remain in implementation or enabling phases and are experiencing minor delays relating to approvals, system dependencies and resource capacity, all

remain within agreed tolerances and continue to provide confidence in the delivery of increasing Hear and Treat, improving access to alternative pathways and reducing avoidable ED conveyance.

3.1.2 ***So what:***

Over Q1 more of our patients received clinical advice over the phone and fewer of our patients were conveyed to ED which supports increasing ambulance availability. Significant peaks in demand on day and during hot weather led to patients waiting longer than planned when calling our 999 contact centres.

Collectively, these workstreams are strengthening the Trust's ability to deliver the Right Response by improving clinical capacity, increasing access to alternative care pathways, and enabling more integrated decision-making across urgent and emergency care services. The projects are expected to support sustained improvements in Hear and Treat performance, reduce avoidable Emergency Department conveyance, improve patient access to the most appropriate care, and make more effective use of clinical resources.

The implementation of iCAS Phase 2 and Common CAD provides important enabling infrastructure for future service integration, productivity gains and system-wide efficiencies. While some benefits will be realised later in the year or beyond 2026/27, progress during Q1 provides assurance that the foundations are being established to support delivery of the Trust's strategic objectives.

3.1.3 ***Challenges and Learning***

Across the Strategic Priority 1 workstreams, the main challenges relate to call demand, EHA recruitment and call handling efficiencies. While demand is broadly in line with plan we have seen significant spikes on day and during hot weather in June which has created capacity challenges leading to reduced performance. Alongside this course fill for EHA training has been below plan in Q1 and is off track for Q2 while call handler downtime is also below optimum levels.

EHA training courses planned for summer months have been difficult to fill with candidates not able to commit to 6 weeks training without leave over the school holiday period and will inform course planning in future years. Early activity has identified opportunities to improve SPUC confidence in remote triage, referral acceptance rates and pathway utilisation through targeted training, enhanced reporting and closer collaboration with system partners. Despite some minor delays and resource pressures, mitigation plans are in place and the challenges identified are providing valuable insight to inform implementation, maximise benefit realisation and support delivery of the Trust's Right Response objectives.

3.1.4 ***What next:***

During Q2, focus will move from planning and design into implementation across the Strategic Priority 1 workstreams. Key priorities: include addressing call handler recruitment shortfall with additional training courses and expansion of 999 capacity at Callflex to increase our recruitment pool, reducing call handler down time to improve efficiency and undertaking work to better align resources to call demand. Work is also underway finalising the design and implementation requirements for the integrated clinical queue, and completing training, testing and go-live preparations for the Common CAD implementation.

3.2 STRATEGIC PRIORITY 2: IMPROVE OPERATIONAL PRODUCTIVITY AND PERFORMANCE

3.2.1 *Q1 position and why:*

Operational productivity indicators remained under pressure at the end of Q1. **Category 2 mean** response times deteriorated during June and were 1 minute 39 seconds slower than the planned trajectory, with performance impacted by challenging operating conditions, including the late-June heatwave. Regional variation remained evident, with the South experiencing the greatest deviation from plan. **Crew clear** times also remained above 3 minutes worse than trajectory, with Q1 target not achieved given the scale of improvement required following deterioration in performance during Q4. This was partly driven by delays to implementing the MIS auto alert module which notifies crews via radio when approaching the 15-minute window. Work to update ID cards to identify staff in the telematics system on each vehicle is behind plan with 35% updated over Q1 with 50% needed to move plans forward.

Delivery across Strategic Priority 2 is progressing but remains variable, with workstreams ranging from Red to Amber/Green. Progress has been made across operational productivity initiatives, including **Crew Clear**, **Crew Line, HCP Transportation** and **Realising Telematics Benefits**, with governance structures established, discovery activity underway and improvement interventions being developed. However, several projects to improve alignment of resources to demand are in the planning, discovery or approval stages, with progress impacted by delays to modelling activity, governance sign-off and resource dependencies. As a result, whilst there is confidence that the programmes, projects and workstreams are moving in the right direction, the majority have not yet reached the stage where measurable operational benefits can be fully realised.

3.2.2 *So what:*

Delays to roll out of the auto alert module mean early planned benefits have not been delivered. As a result crew clear times remained higher than plan impacting on crew availability which reduces our capacity to respond and impacts on response times. While improving alignment of resource to demand is a multi-year workstream and was not expected to deliver benefits in year if sufficient progress isn't made then efficiencies will not be realised to support performance in 27/28. Increased Crew Line provision in each area is reducing demand on EOC clinicians with the percentage of Crew Line calls taken by EOC falling to 43% in June which is 600 calls less than June last year. This is freeing up EOC clinicians to deliver hear and treat supporting the improved performance seen over Q1. Until staff can be identified on vehicles managers cannot begin to share driving data with staff or take corrective action with outliers to deliver telematics benefits.

Collectively, these workstreams support the Trust's ambition to improve operational productivity, maximise frontline resource availability and deliver sustainable improvements in Category 2 response performance. Whilst many of the programmes remain in discovery, design or implementation phases, they are establishing the foundations required to deliver longer-term benefits including improved response times, reduced variation in performance, increased operational resilience and more efficient use of Trust resources.

3.2.3 *Challenges and Learning*

Across the Strategic Priority 2 workstreams, the main **challenges** relate to MIS capacity with priority given to Common CAD, completing discovery and modelling activity and securing governance approvals. As the planned improvement from this has not been realised.

Progress in several programmes remains dependent on evidence gathering, operational research, system development and behavioural change, with risks also linked to stakeholder engagement, adoption of new processes and embedding change into day-to-day operational practice.

Learning from Q1 has reinforced the importance of robust data, modelling and performance analysis to identify root causes and target improvement activity effectively. Work undertaken to date has highlighted variation in operational practices, workforce deployment, pathway utilisation and local processes, demonstrating the need for greater consistency, stronger governance and improved use of performance information. Early implementation experience has also emphasised the importance of stakeholder engagement, clear communication and evidence-based decision-making to support sustainable operational improvement and benefits realisation.

3.2.4 ***What next:***

During Q2, the focus will be on moving the Strategic Priority 2 workstreams from discovery and design into implementation. Key priorities include completing demand, capacity and rest break modelling, finalising recommendations and business cases for operational improvement, and progressing implementation planning to better align resources with patient demand.

Specific activity will focus on progressing **Crew Clear** with work on management presence at ED and self-handover now to be prioritised to mitigate MIS delays**.** Work on **HCP transportation** processes, implementing the enhanced **Crew Line** operating model, embedding telematics reporting, telematics systems training and performance management arrangements across operational services will also move forward. Collectively, these programmes will seek to establish the evidence, systems, governance and operational changes required to deliver improved productivity, increased ambulance availability, reduced variation in performance and sustainable improvements in **Category 2** response times during the remainder of 2026/27 and beyond

3.3 <u>STRATEGIC PRIORITY 3: SUPPORT OUR PEOPLE</u>

3.3.1 ***Q1 position and why:***

At Q1, **sickness absence** increased slightly, rising to 7.7% in June and remaining 1.2 percentage points above plan. Long-term sickness a concern, with short-term sickness also increasing, highlighting ongoing workforce attendance pressures.

Across the three supporting workstreams, progress has been made in developing key interventions, including manager engagement and wellbeing initiatives, the **Alternative Duties Framework** and associated digital application, and implementation of the new **Workplace Adjustments** Policy. However, all workstreams are reporting Amber ratings due primarily to delays in formal governance documentation and minor slippage against planned milestones. While delivery remains within agreed tolerances and no significant risks to overall

objectives have been identified, continued focus is required to complete governance approvals and maintain momentum in implementing the planned improvements.

3.3.2 ***So what:***

At the end of Q1, the three workstreams continue to provide important foundations to support the Trust's ambition to reduce sickness absence and improve workforce wellbeing, productivity and staff experience. The alternative duties app will increase visibility of alternative duties opportunities for staff and managers supporting more staff to remain in work. Collectively, these initiatives are intended to create a more inclusive and supportive working environment, help colleagues remain in or return to work where appropriate, and establish the conditions necessary to support sustainable reductions in sickness absence and improved workforce outcomes over the longer term.

3.3.3 ***Challenges and Learning:***

At the end of Q1, delivery has highlighted a number of common challenges across the sickness absence improvement workstreams, principally balancing project activity with operational pressures and progressing formal governance arrangements alongside implementation. Additional challenges include ensuring effective stakeholder engagement, aligning policy, process and technology developments, and establishing the infrastructure required to embed new ways of working consistently across the Trust. Early delivery has generated valuable learning regarding managers' experiences of attendance management, the importance of engaging stakeholders in the design of solutions, and the need for clear guidance, streamlined processes and appropriate support mechanisms to enable successful implementation. This learning will inform the next phase of delivery and support the sustainable adoption of improvements across the organisation.

3.3.4 ***What next:***

During Q2, the focus will be on addressing governance and implementation priorities to support continued delivery of the sickness absence improvement programme. Key activities include completing outstanding workstream documentation and governance approvals, progressing stakeholder consultation and engagement, and finalising the supporting frameworks, processes, guidance and digital solutions required across all three workstreams. Further work will focus on strengthening manager capability, raising awareness of new arrangements, increasing access to workplace support and adjustments, and ensuring that implementation arrangements are embedded effectively within business-as-usual services. These activities are intended to maintain delivery against planned milestones and establish the foundations necessary to support longer-term improvements in workforce wellbeing, attendance and productivity.

3.4 <u>STRATEGIC ALIGNMENT:</u>

The three strategic priorities in the 2067/27 Business Plan make direct contributions to the 2024-29 Strategy and are directly aligned to the **YAS Bold Ambitions**, with the strongest links to **Our Patients** and **Our People**, and supporting contributions to **Our Partners** and **Our Planet and Pounds**. The programmes focused on Right Response and Operational Productivity are closely aligned to **Our Patients**, as they aim to improve timeliness, responsiveness, access to appropriate care pathways and patient experience through better service integration, operational efficiency and

use of technology. The sickness and workforce-related programmes align most directly to **Our People**, supporting a healthier, more supported and inclusive workforce through improvements in attendance, workplace adjustments and alternative duties arrangements. Several workstreams, particularly care pathways, iCAS Phase 2, HCP redirection and wider system-facing initiatives, also support **Our Partners** by requiring stronger collaboration with health and care partners to improve joined-up care, pathway utilisation and population outcomes. Finally, the productivity, telematics, fleet, rota, rest break and resource alignment programmes contribute to **Our Planet and Pounds** through a focus on sustainable use of workforce, fleet and operational resources, improved efficiency, and better value from existing capacity. Overall, the portfolio is well aligned to the Bold Ambitions, although most areas are currently at an early stage of delivery, so the full contribution to these objectives will strengthen as programmes move from mobilisation into implementation and benefits realisation.

4.0 RISKS

4.1 The principal risks relate to the pace of transition from mobilisation into implementation and the extent to which planned benefits can be realised within 2026/27. While delivery is broadly progressing, many workstreams remain in discovery, design, approval or early implementation phases, meaning that the Board should note that Q1 assurance is currently more strongly weighted towards mobilisation and delivery control than realised operational, workforce or patient benefit.

1. **Benefits realisation risk:** Many workstreams remain in mobilisation, discovery, design or governance phases, so measurable benefits are limited at Q1. If implementation does not accelerate in Q2, benefits may slip into later quarters or beyond 2026/27.
2. **Operational performance risk:** Category 2 response times are off trajectory and deteriorated in June. Crew Clear remains significantly above plan, reducing ambulance availability and contributing to response time pressures which may result in agreed targets being missed.
3. **Resource-to-demand alignment risk:** The resource alignment programme is rated Red and remains dependent on modelling, analysis, governance decisions and potentially sensitive workforce changes. Failure to progress this work could limit performance improvement in 2026/27 and weaken preparedness for 2027/28.
4. **999 call handling and EHA recruitment risk:** Call handling performance is under pressure, with demand spikes and recruitment behind plan. Continued recruitment or training delays could affect call answer performance and patient access during Q2 and may extend later into the year.
5. **Workforce sickness and availability risk:** Sickness absence remains above plan at 7.7%, with both long-term and short-term sickness pressures which may impact operational capacity and increase overtime requirements to achieve performance.

5.0 FINANCIAL IMPLICATIONS

5.1 Failure to achieve agreed NHSE targets linked to the risks identified above on call handler numbers and DCA hours which may be impacted by sickness could impact on the second tranche of growth funding of £6.16m.

6.0 NEXT STEPS

6.1 The monthly operations and quarterly corporate performance processes will continue to monitor ongoing business plan priorities and deliverable workstreams aligned to the Performance Management Framework. Identified actions will be supported through the performance process, with escalation to TEG, Board Assurance Committees and Trust Board where appropriate.

7.0 RECOMMENDATIONS

7.1 It is recommended that the Trust Board:

1. Notes the Q1 delivery position against the 2026/27 Business Plan, including the current RAG+ ratings across the 17 workstreams.
2. Takes assurance that delivery is broadly progressing as expected for this stage of the year, with the majority of workstreams within tolerance and governance, delivery and implementation arrangements are continuing to develop.
3. Notes that benefits realisation remains limited at Q1, with many workstreams still in mobilisation, discovery, design or early implementation phases, and that delivery confidence is dependent on accelerated implementation during Q2.
4. Notes the key risks set out in section 4, particularly Category 2 performance, Crew Clear, 999 call handling capacity, EHA recruitment, resource-to-demand alignment and sickness absence.

8.0 SUPPORTING INFORMATION

8.1 Attached Appendices:
Appendix 1: Priority 1-8 workstream details
Appendix 2: 5-Colour RAG+ System for Business Plan Workstream Progress Tracking
Appendix 3: National Oversight Framework Q4 2025-26
Appendix 4: Key Metrics Table

APPENDICES

Appendix 1 Priority 1-3 workstream details

STRATEGIC PRIORITY 1 - RIGHT RESPONSE:

Increase Hear and Treat and reduce ED conveyance

Executive Lead Summary: Marc Thomas

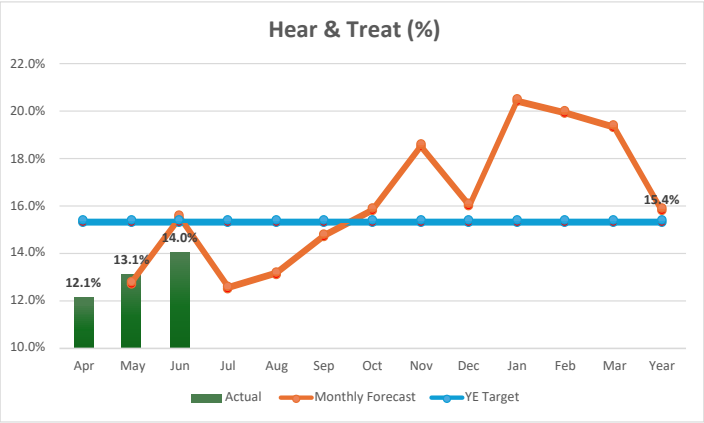
YAS will increase Hear and Treat to 15.4% and reduce ED conveyances by 1.3%, ensuring every patient receives the right response at the earliest point in their journey.

The following workstreams, programmes and projects have been identified to support delivery of this priority:

	Q1 RAG
1.1 Expanding EOC clinical capacity - SPUC/SPMH utilisation	
1.1.1 Expanding the Remote Clinical Hub	GREEN
1.1.2 Achieving Clinical Recruitment	AMBER/GREEN
1.1.3 Expanding SPUC & SPMHT H&T Utilisation	AMBER/GREEN
1.2 Optimising Integration – Clinical Queue, iCAS Phase 2 and Joint CAD	
1.2.1 Implementing iCAS Phase 2 (Joint Clinical Queue)	AMBER
1.2.2 Implementing Common CAD for 111	AMBER
1.2.3 Preparing for PTS CAD Implementation (2027/28)	NOT REPORTING
1.3 Optimising Alternative Pathways - Push & On Scene	AMBER
1.4 Achieving EHA Recruitment	AMBER

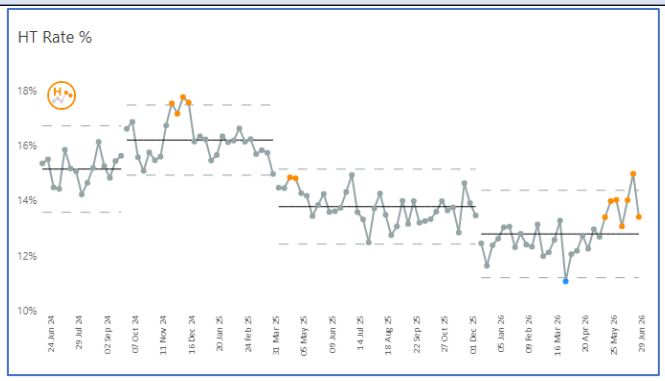
What?
What is the position at Q1 & Why?

The Hear and Treat rate improved from 13.1% to 14.0% in June, although performance remains 0.3 percentage points below target. A significant programme of clinician recruitment is planned throughout 2026/27, with further improvement expected from September as staff recruited in Q1 complete training, develop competency and begin contributing fully to service delivery.

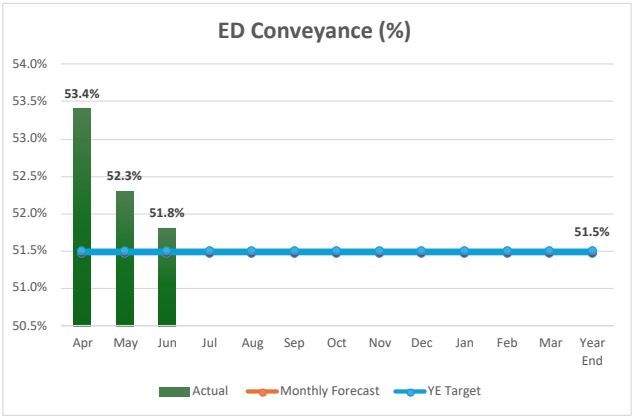


STRATEGIC PRIORITY 1 - RIGHT RESPONSE:

Increase Hear and Treat and reduce ED conveyance



The ED conveyance rate improved to 51.8% in June, a reduction of 1.6 percentage points from April, and an improvement on that reported in June 2025 (0.4 percentage points lower).



The **SPUC/SMPH utilisation project** is rated Amber/Green at the end of Q1, reflecting good delivery progress alongside minor delays to project planning and approval activities. Governance arrangements are now in place, including project and oversight groups, key SPUC actions have been completed on time, outcome metrics are being monitored, and training materials have been developed. Whilst the Project Initiation Document was delayed and remains subject to final approval, overall delivery remains within tolerances, and the project has improved from Amber during the quarter.

The **Implementing iCAS Phase 2 (Joint Clinical Queue)** workstream is rated Amber – Within Tolerances but at Risk at the end of Q1. Progress has been made in establishing governance arrangements, programme oversight, and two supporting workstreams, with design activity underway for the future joint clinical queue. However, completion of project planning documentation, minor delays in queue design activity, and dependencies on other programmes have resulted in the Amber position. Benefits are currently rated Red as no direct Hear and Treat or ED conveyance benefits are expected to be realised during 2026/27 while the new model is being implemented and embedded.

At the end of Q1, the **Implementing Common CAD for 111** project is rated Amber – Within Tolerances but at Risk. Progress has continued on the Phase 2 implementation for 111 services, with the delayed CAD software update successfully completed, training materials developed, approximately 400 users scheduled for training, draft go-live arrangements established, and implementation remaining on track for deployment. However, risks remain around testing scope, access to historical Adastra data, training capacity, and a newly identified clinical safety hazard that requires further mitigation.

STRATEGIC PRIORITY 1 - RIGHT RESPONSE: Increase Hear and Treat and reduce ED conveyance	
	The **Optimising Alternative Pathways - Push & On Scene** workstream is rated Amber/Green – Minor Risks/Delays at the end of Q1. Good progress has been made across all seven project areas, including improving mental health and primary care PUSH referrals, strengthening on-scene pathways, developing digital referral solutions, enhancing pathway reporting, and progressing improvements to the hospital directory. Whilst delivery performance remains on track, the overall rating reflects delays in finalising project governance documentation, the appointment of a Delivery Lead, and minor slippage in some digital and reporting workstreams. Confidence in benefit realisation remains positive, with clear measures and dashboards in place to support monitoring.
So what? ***What does this mean for the Trust?***	The **SPUC/SMPH utilisation** project supports the Trust's **Right Response** priority by increasing the utilisation of Specialist Paramedics in Urgent Care (SPUC) and Specialist Paramedics in Mental Health (SPMH) during EOC rotations, with the aim of increasing Hear and Treat activity and reducing avoidable Emergency Department conveyance. Benefits monitoring arrangements are in place and the project is expected to contribute to improved clinical decision-making, enhanced patient outcomes and better system efficiency through greater use of specialist clinical expertise within the EOC. The **Implementing iCAS Phase 2 (Joint Clinical Queue)** workstream remains an important enabler of the Trust's Right Response ambition, seeking to create a single integrated clinical queue across services to support more efficient clinical decision-making and improve patient access to the most appropriate care. Whilst direct benefits are not expected within 2026/27, successful implementation will establish the foundations for future improvements in Hear and Treat performance, reduced avoidable conveyance, and greater operational efficiency from 2027/28 onwards. The **Implementing Common CAD for 111** project is a key enabler of greater integration across 999 and 111 services, supporting improved interoperability, streamlined clinical workflows, and future efficiency savings. Delivery of Phase 2 will provide a common CAD platform for urgent and emergency care services, helping to strengthen system resilience and support integrated patient care. However, the pause in Phase 3 Patient Transport Services (PTS) implementation means some anticipated benefits, efficiencies and business plan milestones may not be fully realised within the original timeframe. The **Optimising Alternative Pathways - Push & On Scene** workstream directly supports the Trust's Right Response ambition by improving access to alternative pathways and increasing opportunities to avoid unnecessary conveyance to Emergency Departments. Improvements to PUSH services, strengthened system partnerships, enhanced referral processes and better pathway visibility are expected to increase Hear and Treat and See and Treat activity, improve patient access to appropriate care, and support more effective use of ambulance resources. Benefits are forecast to begin being realised from September 2026 and will be monitored through dedicated pathway utilisation dashboards.
Challenges/ Learning	For **SPUC/SMPH utilisation,** the principal challenges relate to completing project governance approvals, managing the transition of key leadership roles as the current SRO and Delivery Lead leave the Trust, and ensuring sufficient

STRATEGIC PRIORITY 1 - RIGHT RESPONSE: Increase Hear and Treat and reduce ED conveyance	
	training capacity to support SPUC refresher training. A small number of activities within the SPUC action plan have experienced short delays due to governance sign-off requirements. Learning to date highlights the need to address longstanding barriers associated with SPUC EOC rotations and to strengthen confidence and capability for Hear and Treat activity through targeted training and support. The principal challenge for the **Implementing iCAS Phase 2 (Joint Clinical Queue)** workstream is the project's dependency on the Common CAD programme, with both initiatives drawing on the same specialist resources and technical support. Additional risks remain around the scale of system development required, available MIS capacity, and any future funding requirements should greater configuration changes be needed. Early design work has highlighted the complexity of developing the future-state queue model, including determining how specific call categories will be managed within the integrated approach. The principal challenges for the **Implementing Common CAD for 111** project relate to ensuring sufficient testing is completed ahead of implementation, identifying a sustainable solution for retaining access to Adastra data following contract expiry, and mitigating clinical safety risks associated with future operational processes. In addition, work on the PTS phase has been paused, resulting in an escalation as three planned business plan milestones are unlikely to be delivered during 2026/27. These factors highlight the importance of robust assurance, safety governance and dependency management as the programme progresses towards go-live. Early delivery of the **Optimising Alternative Pathways - Push & On Scene** workstream has identified variation in referral acceptance rates across system partners and differences in pathway utilisation across localities, requiring targeted engagement and collaboration to address barriers. The project has also highlighted the importance of robust data and reporting to build clinician confidence and maximise pathway use. Some workstreams have experienced minor delays due to governance approvals, BI capacity constraints and stakeholder availability, although recovery plans are in place. Two project issues remain open relating to the appointment of a new SRO and Delivery Lead following planned leadership changes.
What next?	For **SPUC/SMPH utilisation**, the focus during Q2 will be on securing final approval of project documentation, implementing the SPUC improvement plan, delivering refresher training, and progressing actions to address training capacity risks. The SPMH element of the programme will formally commence, with governance arrangements established and baseline activity monitored. Ongoing performance tracking will be used to evaluate improvements in Hear and Treat activity and support delivery of the forecast benefits across both SPUC and SPMH workstreams. During Q2, the focus for the **Implementing iCAS Phase 2 (Joint Clinical Queue)** workstream will be on completing the design of the joint clinical queue, understanding the extent of any system-led changes required, and developing testing arrangements to support implementation. Work will continue to progress training materials, workforce modelling and reporting requirements, while monitoring dependencies with the Common CAD programme. These activities will ensure the Trust is prepared to implement the integrated clinical queue once enabling conditions are in place.

STRATEGIC PRIORITY 1 - RIGHT RESPONSE: Increase Hear and Treat and reduce ED conveyance	
	The focus in Q2 for the **Implementing Common CAD for 111** project will be on completing user training, finalising system configuration, undertaking supplier and user acceptance testing, securing approval of the DPIA, completing the clinical safety case and finalising standard operating procedures. Preparations for go-live in August 2026 will continue, alongside decisions regarding long-term Adastra data access arrangements and further consideration of the future approach to the paused PTS element. Going forward into Q2, the **Optimising Alternative Pathways - Push & On Scene** workstream will focus on implementing improvement plans with system partners, progressing digital GP and falls referral developments, enhancing pathway utilisation reporting, and advancing local pathway initiatives across West Yorkshire, South Yorkshire and Humber and North Yorkshire. Work will continue to improve mental health and primary care PUSH referrals, strengthen clinician feedback mechanisms and progress the redesign of the JRCALC hospital directory. These activities are intended to support increased pathway utilisation, improved referral acceptance rates and delivery of the programme's expected benefits.

STRATEGIC PRIORITY 2 - IMPROVE OPERATIONAL PRODUCTIVITY & PERFORMANCE:

Improve performance including Category 2

Executive Lead: Marc Thomas

YAS will reduce Category 2 average response times to 00:24:44 and minimise variability across the day and geography through improving operational efficiencies

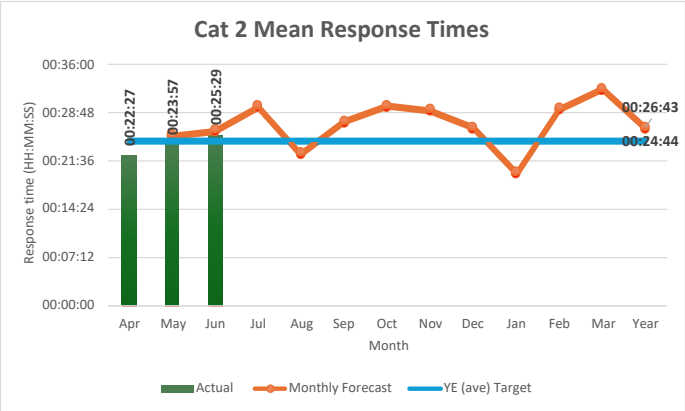
The following workstreams, programmes and projects have been identified to support delivery of this priority:

Workstream Programme	Project & Support	Q1 RAG
2.1Improve alignment of resource to demand	1. Demand, Capacity and Performance Analysis	RED
	2. Flexible Working Arrangements	
	3. Rotas	
	4. Scheduling Process	
	5. Fleet Alignment	
	6. New 999 Operations Rest Break SOP	AMBER
2.2 Improving Turnaround (Crew Clear)		RED
2.3 Redirecting Inappropriate Healthcare Professional (HCP) Transportation Requests (09:00–16:00)		AMBER
2.4 Enhancing Crew Line		AMBER
2.5 Realising Telematics Benefits		AMBER/GREEN

What?
What is the position at Q1 & Why?

Category 2 mean response time in June was 25 minutes 29 seconds, an increase on the previous month and 1 minute 39 seconds below the trajectory target. June performance coincided with a significant national heatwave between 22 and 26 June 2026, during which England experienced record-breaking temperatures and health service providers operated under elevated heat-health alerts. YAS activated adverse weather arrangements and increased escalation measures in response to the forecast pressures, which may have contributed to increased demand and operational pressures affecting response times.

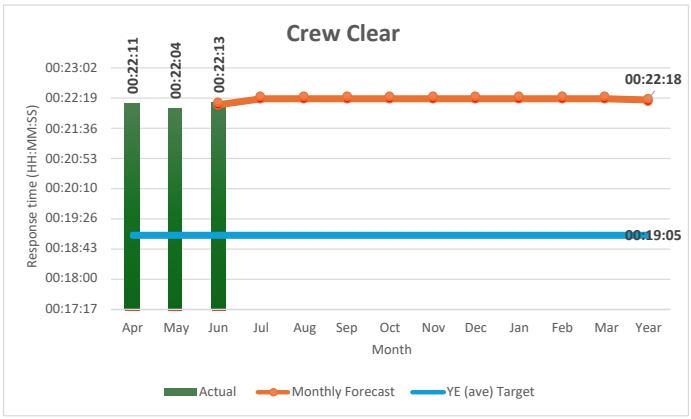
All areas performed below plan during June, reflecting the impact of challenging operating conditions, although variation across regions remained evident. HNY and the West remained relatively close to trajectory at 6 seconds and 34 seconds below plan respectively, while performance in the South was further from plan, with response times 2 minutes and 13 seconds slower than expected.



STRATEGIC PRIORITY 2 - IMPROVE OPERATIONAL PRODUCTIVITY & PERFORMANCE:

Improve performance including Category 2

Crew clear time was up marginally in June, rising by 9 seconds to 22 minutes 13 seconds. Performance remains above the planned trajectory at 3 minutes 17 seconds higher than plan. Achievement of the Q1 trajectory was not achieved, as the target was established in November based on the level of improvement seen earlier in the year. Performance deteriorated during Q4, ending the year worse than plan, resulting in a requirement for a significant improvement of approximately three minutes between Q4 and Q1 to return to trajectory.



The **Improve Alignment of Resource to Demand programme** is rated Red, reflecting delays in business planning, outstanding delivery lead appointments and the need to complete discovery and modelling work before improvement actions, timescales and benefits can be confirmed. Internal demand and capacity modelling has commenced, project governance arrangements are in place and discovery work is underway; however, progress remains dependent on completing the analysis needed to identify the most effective interventions.

The **New 999 Operations Rest Break Standard Operating Procedure** which is a workstream within the Improve Alignment of Resource to Demand programme is rated Amber, with progress affected by delays in receiving operational research modelling required to assess the current rest break arrangements and inform future options. Business planning is complete and initial discovery activity has commenced, but project documentation, delivery leadership arrangements and modelling outputs remain outstanding.

The **Improving turnaround (Crew Clear)** project is rated Amber/Red – Significant Risk at the end of Q1. The project commenced later than planned and timescales for key digital enablers, particularly the proposed auto-alert functionality, are yet to be confirmed. Despite these challenges, discovery activity is progressing well, with data collection, variation analysis, benchmarking with other ambulance services and development of an initial recommendations report all underway.

The **Redirecting Inappropriate Health Care Professional (HCP) Transportation Requests** project is rated Amber – Within Tolerances but at Risk. Progress has been made in establishing project governance, commencing data analysis and developing project documentation, with the first project group meeting completed and initial BI data reviewed. The Amber rating reflects the need to finalise project planning documentation, including the PID, and the fact that the project started later than originally planned.

The **Enhancing Crew Line** project is rated Amber – Within Tolerances but at Risk at the end of Q1. Good progress has been made, with key discovery activity completed, improvement interventions developed, new performance

STRATEGIC PRIORITY 2 - IMPROVE OPERATIONAL PRODUCTIVITY & PERFORMANCE: Improve performance including Category 2	
	measures agreed, and the project reaching approximately 56% completion. The Amber rating reflects a delay in securing approval of revised crew line staffing criteria and governance arrangements through the Clinical Governance Group (CGG), together with delays in finalising project documentation following business planning timescales. The **Realising Telematics Benefits Realisation** project is rated Amber within tolerances but at risk at the end of Q1. Delivery is progressing broadly in line with plan, with key workstreams established, action owners identified and implementation activity underway. The Amber rating reflects delays in finalising the PID and agreeing tolerances between Fleet and Operations, alongside delays in updating staff ID cards for use on the system. Overall, delivery remains on track but action is required to progress ID card updates.
So what? ***What does this mean for the Trust?***	The **Improve Alignment of Resource to Demand programme** is intended to support delivery of Strategic Priority 2 by improving operational productivity, increasing frontline resource availability and reducing unwarranted variation in Category 2 response times. While benefits have not yet been quantified, the programme is expected to identify opportunities to better align workforce, fleet, scheduling, rota and rest break arrangements with patient demand, helping to improve resilience, productivity and operational performance across 999 services. The discovery-focused approach provides assurance that future decisions will be evidence-based and informed by detailed modelling and analysis. The **Improving turnaround (Crew Clear)** project is intended to support delivery of Strategic Priority 2 by reducing Crew Clear times, improving hospital turnaround performance and increasing ambulance availability to respond to patient demand. Successful delivery would contribute to improved Category 2 response times, reduced variation in operational performance across the Trust and more effective use of frontline resources. While benefits have not yet been validated, the work currently underway is helping to build an evidence base to identify the interventions most likely to deliver sustainable operational improvements. The **Redirecting Inappropriate Health Care Professional (HCP**) **Transportation Requests** project supports Strategic Priority 2 by seeking to ensure emergency ambulances are reserved for patients who require an emergency response, reducing inappropriate Healthcare Professional (HCP) transportation requests and improving ambulance availability for Category 1 and Category 2 incidents. Successful delivery is expected to reduce inappropriate HCP requests, lower avoidable conveyance and contribute to improved operational productivity and Category 2 response performance. Benefits have been identified and are measurable, including a planned reduction in the proportion of HCP requests requiring an emergency ambulance response. The **Enhancing Crew Line** project supports the Trust's **Right Response** ambition by strengthening the Crew Line function and improving access to alternative care pathways. The intended outcome is to provide more timely clinical support to frontline crews, improve on-scene decision-making, increase See and Treat and Hear and Treat outcomes, reduce unnecessary conveyance to Emergency Departments, and improve operational efficiency. The introduction of revised performance measures will also provide clearer

STRATEGIC PRIORITY 2 - IMPROVE OPERATIONAL PRODUCTIVITY & PERFORMANCE: Improve performance including Category 2	
	evidence of the project's contribution to reduced job cycle times, increased local Crew Line activity and reduced demand on EOC resources. The **Realising Telematics Benefits** project supports Strategic Priority 2 by embedding telematics data into operational and fleet management processes to improve productivity, fleet utilisation and operational performance. It is expected to contribute to improved resource availability, more efficient fleet usage, safer driving behaviours and reduced costs. The project has identified measurable benefits, including a reduction in fuel consumption and avoidable collisions, alongside broader benefits relating to workforce wellbeing, operational resilience and performance management.
Challenges/ Learning	The principal challenge within The **Improve Alignment of Resource to Demand** programme is the need to complete detailed modelling and discovery activity before improvement opportunities, benefits and implementation plans can be confirmed. Delays in business planning, project initiation documentation, delivery lead appointments and modelling activity have impacted progress, while dependencies on operational research and analytical capacity have highlighted the importance of establishing robust evidence before committing to operational change. Early learning has reinforced the need for high-quality demand, workforce and performance data to ensure that any future interventions deliver measurable improvements in operational performance. The key challenges for the **Improving turnaround (Crew Clear)** project relate uncertainty around the delivery timescales for auto-alert functionality and competing demands on digital and MIS resources, which have resulted in an escalation to the Business Plan Oversight Group. As the project is testing interventions such as self-handover and auto-alerts before wider implementation, confidence in benefit realisation remains dependent on pilot outcomes. Early learning has reinforced the importance of understanding variation in local practice, using data-driven analysis to identify root causes, and ensuring operational and digital resources are aligned to support implementation. For the **Redirecting Inappropriate Health Care Professional (HCP**) **Transportation Requests** project, the main challenges relate to achieving behavioural change amongst healthcare partners, ensuring sufficient alternative pathways exist to support redirection of inappropriate requests, and maintaining consistency in the recording and classification of HCP activity. Early work has highlighted the importance of robust data analysis, clinical audit and engagement with partner organisations and Integrated Care Systems to understand current demand, identify variation and support adoption of future process changes. Risks remain under active management and will continue to be monitored through established governance arrangements. For the **Enhancing Crew Line** project the principal challenge has been securing agreement to revised governance and staffing arrangements, resulting in a delay to final approval of the updated Crew Line SOP and governance framework. Learning from the discovery phase has highlighted variation in local Crew Line operating models, staffing approaches and call handling arrangements across areas. This has reinforced the need for a more consistent operational model, strengthened governance arrangements and

STRATEGIC PRIORITY 2 - IMPROVE OPERATIONAL PRODUCTIVITY & PERFORMANCE: Improve performance including Category 2	
	clearer performance monitoring to maximise the benefits of the Crew Line function across the Trust. Key challenges associated to the **Realising Telematics Benefits** project relate to staff engagement, ensuring telematics data is routinely used to inform decision-making, and embedding the benefits of the system into day-to-day operational practice. Risks remain around staff perceptions of telematics, consistency of managerial use, behavioural change and maintaining confidence in the data. Early learning has highlighted the importance of clear communication, robust governance, consistent reporting and demonstrating how telematics supports safety, performance improvement and organisational efficiency rather than being perceived solely as a monitoring tool.
What next?	During Q2, the focus for The **Improve Alignment of Resource to Demand** programme will be on completing demand, capacity and rest break modelling, reviewing the findings and developing evidence-based improvement actions. For the resource-to-demand workstream, this will include identifying priority changes relating to rotas, flexible working arrangements, scheduling processes and fleet alignment, alongside reviewing project timelines and governance arrangements. For the rest break project, the next steps are to complete the discovery phase, confirm whether changes to the current SOP are required, develop recommendations and progress approvals. Together, these activities will establish a clearer understanding of the potential benefits and support informed decision-making on future implementation. The **Improving turnaround (Crew Clear)** project Q2 focus will be on finalising the diagnostic and recommendations report, securing agreement on proposed interventions and confirming implementation timescales for auto-alert functionality. Testing of improvement initiatives, including self-handover arrangements, will continue alongside the development of a Trust-wide Crew Clear operating framework and supporting governance arrangements. Work will also progress to establish a wider project group and prepare for implementation and benefits tracking once preferred interventions have been agreed. Q2 focus for the **Redirecting Inappropriate Health Care Professional (HCP**) **Transportation Requests** project will be on completing the discovery and analysis phase, including further review of BI data, clinical audit findings and national HCP framework guidance. This work will inform the development of recommendations, an implementation plan and a revised HCP process and framework. Subject to approval, the project will then progress into pilot testing within identified areas of opportunity before wider implementation, supporting delivery of the expected benefits and improved operational efficiency. The Q2 focus for the **Enhancing Crew Line** project will be on securing approval of the revised Crew Line SOP and governance arrangements, implementing the enhanced Crew Line model across localities, introducing a formal audit process, and reviewing area-based staffing arrangements to support a more consistent approach. Work will also continue to establish sustainable 24/7 operational coverage, embed the agreed performance measures, and monitor the impact on patient outcomes, operational efficiency and alternative pathway utilisation.

STRATEGIC PRIORITY 2 - IMPROVE OPERATIONAL PRODUCTIVITY & PERFORMANCE: Improve performance including Category 2	
	During Q2, the focus for the **Realising Telematics Benefits** project will be on increasing communications and engagement, progressing the agreed workstreams, completing project documentation and continuing implementation of telematics reporting, applications, training processes and supporting policies. Work will also continue to embed telematics data into operational management processes, develop staff understanding of the benefits, and establish the foundations for realising the anticipated reductions in fuel usage, avoidable collisions and wider operational performance improvements.

Appendix 1 Priority 1-3 workstream details

STRATEGIC PRIORITY 3 – SUPPORT OUR PEOPLE

Reduce Sickness

Executive Lead Summary: Amanda Wilcock

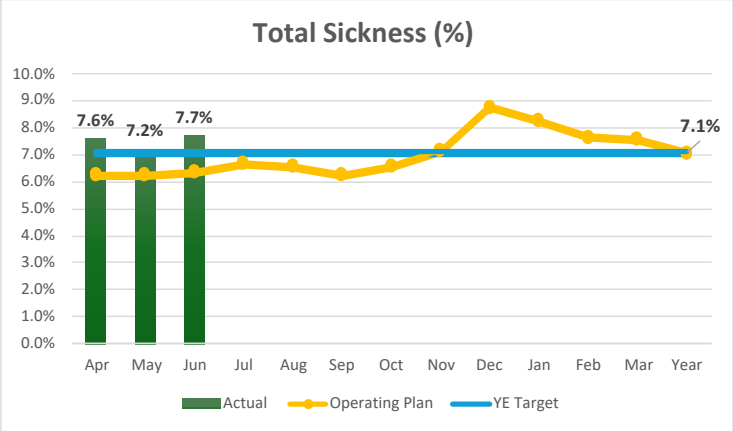
YAS will reduce sickness absence by 0.5% and create a healthier, more skilled and engaged workforce.

The following workstreams, programmes and projects have been identified to support delivery of this priority:

Workstream Programme	Project & Support	Q1 RAG
1. Absence Preventive and Recovery Pathway		AMBER
2. Strengthening Alternative Duties Framework Project		AMBER
3. Enhancing Workplace Adjustments Project		AMBER

What?
What is the position at Q1 & Why?

Sickness absence rose slightly during Q1, rising from 7.6% in April to 7.7% in June and remaining above the operating plan target by 1.2 percentage points. Long-term sickness remains a concern at 4.57%, with a further increase in short-term sickness to 3.09%, highlighting ongoing workforce wellbeing and attendance challenges. The June heatwave may also have been a contributory factor to the increase in sickness absence, placing additional strain on staff working in challenging operational conditions.



At the end of Q1, the **Preventive and Recovery Pathway** workstream is rated **Amber – Within Tolerances but at Risk**. Progress has been made against key delivery activities, including completion of manager listening sessions, analysis of manager feedback, review of existing attendance management training, and development of the draft Wellbeing Commitment Statement. However, the overall rating reflects delays in formal project planning and governance documentation, with approval of the workstream delivery plan and Project Initiation Document behind schedule. In addition, consultation on the Wellbeing Commitment Statement is forecast to complete later than originally planned due to stakeholder availability and competing operational pressures.

At the end of Q1, the Strengthening Alternative Duties Framework workstream is rated **Amber – Within Tolerances but at Risk**. Delivery activity remains broadly on track, with the Alternative Duties Framework in development and the associated digital application approximately 90% complete. However, the

STRATEGIC PRIORITY 3 – SUPPORT OUR PEOPLE Reduce Sickness	
	overall rating reflects delays in formal project governance arrangements, including approval of the workstream delivery plan and Project Initiation Document, together with a minor delay to completion of the application build. At the end of Q1, the **Enhancing Workplace Adjustments** workstream is rated **Amber – Within Tolerances but at Risk**. Delivery activity is largely progressing as planned, with the new Workplace Adjustments Policy formally approved and published on Pulse and work underway to establish supporting processes and resources. The Amber rating is primarily driven by delays in completion of formal project governance documentation, including approval of the workstream delivery plan and Project Initiation Document, together with a slight delay in developing the workplace adjustments hardware and software catalogue.
So what? ***What does this mean for the Trust?***	The **Preventive and Recovery Pathway** workstream continues to support delivery of the strategic objective to reduce sickness absence and strengthen workforce wellbeing by improving managers' capability to manage attendance and support staff recovery. While the project is not expected to deliver measurable sickness reduction benefits during 2026/27 and is considered an enabling initiative, it is establishing important foundations to improve absence management processes, strengthen wellbeing support, and contribute to a healthier and more engaged workforce over the longer term. The **Strengthening Alternative Duties Framework** workstream supports the Trust's sickness reduction ambition by developing a consistent framework to enable staff who are temporarily unable to undertake their substantive role to remain productively engaged in work where appropriate. The project is intended to strengthen attendance management processes, improve workforce productivity and support longer-term reductions in sickness absence. The **Enhancing Workplace Adjustments workstream** supports the Trust's ambition to create a healthier, more inclusive and supportive working environment by improving the workplace adjustments process for staff. Implementation of the new policy and supporting arrangements will help ensure colleagues receive timely and consistent adjustments to enable them to remain in work and perform effectively. While the project is an enabling initiative and is not expected to deliver directly measurable sickness reduction benefits during 2026/27, it is expected to contribute to improved staff experience and support longer-term workforce wellbeing objectives.
Challenges/ Learning	The principal challenge during Q1 for **Preventative and Recovery Pathway** has been balancing stakeholder engagement activity with competing operational demands, resulting in delays to consultation and project governance milestones. Learning from the completed manager survey, listening sessions and process mapping activity has provided valuable insight into managers' experiences of managing absence, identified gaps in existing training and resources, and highlighted opportunities to improve guidance, support and signposting. The work has reinforced the importance of engaging managers early in the design of improvement initiatives to ensure solutions are practical and responsive to operational needs. The main challenge during Q1 for the **Strengthening Alternative Duties Framework** workstream has been progressing formal project governance and planning activity alongside development of the framework and supporting

	application. The project's success is dependent on developing a robust framework that is supported by managers and staff, making effective stakeholder engagement and consultation critical during the next phase. Progress to date has highlighted the importance of aligning policy, process and technology development to ensure the new framework is practical, consistent and capable of being embedded successfully across the organisation. The main challenges for the **Enhancing Workplace Adjustments workstream** relate to completing the supporting infrastructure required to embed the policy consistently across the organisation, including development of the adjustments catalogue, operating procedures and arrangements for ongoing management within business-as-usual processes. The workstream has also identified risks associated with sourcing specialist equipment and support, including procurement timescales and limited technical expertise in some specialist adjustment areas. Early implementation activity has highlighted the importance of clear guidance, manager awareness and streamlined processes to ensure workplace adjustments can be delivered consistently and efficiently.
What next?	During Q2, priority for **Preventative and Recovery Pathway** will be on securing approval of the workstream Delivery Plan and Project Initiation Document, concluding consultation on the Wellbeing Commitment Statement and finalising supporting communications arrangements. Insights from stakeholder engagement will inform the development of additional training, guidance and support for managers. Work will also continue to strengthen the preventative and recovery pathway and maintain progress against agreed 2026/27 milestones. The **Strengthening Alternative Duties Framework** workstream will focus on completing the Alternative Duties Framework and associated application, alongside stakeholder consultation and user acceptance testing. Implementation planning, communications and engagement activity will be progressed to support adoption across the Trust. Work will also continue to strengthen governance arrangements and maintain delivery against agreed business plan milestones. The focus for the **Enhancing Workplace Adjustments workstream** will be on strengthening implementation arrangements through manager awareness and training activity, completion of the workplace adjustments catalogue and development of supporting operating procedures. Progress will also be made on establishing a procurement framework for specialist equipment and support, alongside completion of the Health and Wellbeing Passport review and development of sustainable arrangements for the long-term management of workplace adjustments within business-as-usual services.

Appendix 2: 5-Colour RAG+ System for Business Plan Workstream Progress Tracking

The **RAG+ (Red, Amber Red, Amber, Amber Green, Green)** system provides a nuanced approach to tracking workstream status beyond the traditional RAG model enhancing visibility, accountability, and decision-making. At a High Level:

- **Green** – On track: no issues; milestones and deliverables are progressing as planned.
- **Amber Green** – Minor risks / delays: progress is being made, minor issues need monitoring and resolution.
- **Amber** – Within tolerances but at risk: challenges exist; corrective action in place and required to avoid further delays.
- **Amber Red** – Significant risk: major challenges present, and mitigation efforts are not fully effective.
- **Red** – Off track: significant issues; requires immediate intervention or escalation.

Colour	Indicators	Characteristics	Actions
Green (On Track)	Performance achieving majority of targets; Minimal risks; All primary objectives met; Financial performance within plan	Predictable progress; Consistent; No significant deviations	Maintain current strategies; Continue monitoring
Amber-Green (Minor risks / delays)	Performance achieving most targets; Positive trend; Low-level opportunities identified; Financial performance within plan	Predictable progress; Consistent; No significant deviations	Investigate; Light-touch performance review
Amber (Off track within tolerance)	Performance within tolerances of targets; moderate risks identified; Some objectives partially met; Financial performance off track but within tolerances of plan	Potential performance challenges Requires close monitoring; Some corrective actions in place and needed to avoid further delays/deterioration	Develop mitigation strategy; Increase reporting frequency; Conduct detailed risk assessment; Create corrective recovery / action plan
Amber-Red (Significant risk)	Performance below target; Multiple high-impact risks; Critical objectives at risk; Financial performance off plan	Substantial performance gaps; Potential systemic issues; High intervention requirement	Immediate senior review; Comprehensive recovery plan; Potential resource reallocation; Detailed root cause analysis
Red (Critical Failure)	Performance missing majority of targets; Multiple critical risks; Strategic objectives severely compromised; Financial performance off plan	Fundamental strategic challenges; High risk of project/initiative failure; Requires radical intervention	Immediate intervention; Potential project restructuring/cancellation; Comprehensive strategic review; Detailed analysis

Appendix 3: **NHS OVERSIGHT FRAMEWORK METRICS TABLE**

This table presents a set of key performance metrics used to assess the Trust's performance across several domains, as required by the NHS Oversight Framework. Each metric is reported with its value, unit, score, rank (out of 10), and the average value for comparison. Key insights:

- The Trust is ranked 1st out of the 10 Ambulance Services in England.
- The Trust performs well in staff engagement and advocacy (ranked 1 out of 10).
- Response times they remain better than the average (rank 3/10).
- Sickness absence increased slightly in Q4 but remains a key focus for improvement.
- Financial metrics are stable, with no planned deficit and minimal variance to plan.

Quarter	Segment	Trust in financial deficit?
Q4 2025/26	1 - High performing	No

Domain	Sub-domain	Metric description	Release Frequency	Metric Value	Q4 2025/26					
					Reporting Date	Metric Value	Average value	Metric value change	Metric score	Rank out of 10
Access to services	Urgent and emergency care	Average Category 2 ambulance response time	Monthly	mins	To Mar 2026	26.25	28.93	-0.33 ↑	1.00	3
Effectiveness and experience	Effective out of hospital care	Percentage of ambulance patients conveyed to emergency departments	Monthly	%	To Mar 2026	52.9	48.70	0.20 ↓	3.40	9
	Patient experience	NHS staff survey advocacy score	Annual	out of 10	2025	6.67	6.1	0.09 ↑	1.00	1
Finance and Productivity	Finance	Planned surplus/deficit	Annual plan	%	2025/26	0.00	0.00	0.00 →	1.00	2
		Variance year-to-date to financial plan	Year to date	%	Month 12 2025/26	0.54	0.59	-0.14 ↓	1.00	6
		Combined finance	Year to date	score	Q3 2025/26				1.00	
	Productivity	Relative difference in costs	Annual	%	2024/25	96.71	96.16	0.00 ↓	1.99	6
Patient safety	Patient safety	NHS Staff survey – raising concerns sub-score	Annual	out of 10	2025	6.27	5.94	0.14 ↑	1.00	1
People and workforce	Retention and culture	Sickness absence rate	available monthly - Quarterly aggregated monthly figures	%	Q3 2025/26	8.03	7.74	0.99 ↓	3.91	7
		NHS staff survey engagement theme	Annual	out of 10	2025	6.29	5.91	0.06 ↑	1.00	1

Source: NHS England, 11/06/26

Appendix 4: **KEY METRICS – ANNUAL BUSINESS PLAN 2026/27**

		ACTUAL			FORECAST											
Metric	BASELINE (25/26 YE ave)	Apr-26	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-26	Feb	Mar	26/27 YE Forecast	YE Operating Plan	YE BP Target
STRATEGIC PRIORITY 1 – RIGHT RESPONSE: Increase Hear and Treat and reduce ED Conveyance																
Hear & Treat %	13.4%	12.1%	13.1%	14.0%	12.6%	13.2%	14.8%	15.9%	18.6%	16.1%	20.5%	20.0%	19.4%	15.9%	15.5%	15.4%
ED Conveyance Rate	52.8%	53.4%	52.3%	51.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			51.5%
Conveyance Rate		60.3%	59.0%	58.5%	60.0%	59.7%	58.6%	57.8%	55.9%	57.7%	54.4%	54.8%	55.3%	57.6%	58.30%	
Average Daily Responses at Scene	2,157	2,159	2,173	2,172	2,233	2,067	2,080	2,128	2,136	2,315	2,120	2,083	2,066	2,144	2,180	
STRATEGIC PRIORITY 2 – IMPROVE OPERATIONAL PRODUTIVITY & PERFORMANCE: Improve Performance including Category 2																
Category 2 Mean	00:26:14	00:22:27	00:23:57	00:25:29	00:29:40	00:22:40	00:27:25	00:29:13	00:27:13	00:25:31	00:18:52	00:28:41	00:31:20	00:26:02	00:24:44	00:24:44
Handover to Clear	00:21:53	00:22:11	00:22:04	00:22:13	00:22:21	00:22:21	00:22:21	00:22:21	00:22:21	00:22:21	00:22:21	00:22:21	00:22:21	00:22:18	00:19:03	00:19:05
Arrive to Handover	00:19:14	00:17:28	00:17:57	00:18:01	00:19:35	00:17:20	00:18:09	00:18:04	00:20:10	00:21:13	00:20:58	00:19:45	00:18:44	00:19:03	00:19:23	
Vehicle Availability: DCA	80.2%	81.8%	79.6%	81.6%												
IUC Not Ready Reason Codes – Health Advisor	28.00%	28.20 %	28.20 %	28.00 %	28.00 %	28.00 %	28.00 %	28.00 %	28.00 %	28.00 %	28.00 %	28.00 %	29.00 %	28.00%		
IUC Clinical Call Backs in 1 hour	41.30%	27.40 %	26.60 %	24.90 %	27.4%	26.6%	24.9%	25.5%	26.5%	26.4%	27.0%	26.3%	24.6%	23.0%		
PTS KPI 1 deliver journey times less than 120 mins	97.10%	96.80 %	97.40 %	97.2%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	97.20%	91.30%	
PTS KPI 3 deliver pre planned pick up within 90 mins	89.50%	90.0%	90.4%	90.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	90.2%	90.50%	
PTS KPI 4 Deliver short notice pick up within 120 mins	80.10%	82.4%	80.7%	81.5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	81.50%	88.30%	
PTS patients per vehicle	1.38	1.37	1.37	1.36	1.39	1.41	1.39	1.37	1.41	1.44	1.39	1.41	1.43	1.37	1.36	
PTS Call Handling - answered in 180 seconds	88.00%	88.01 %	96.00 %	98.8 %											90%	
STRATEGIC PRIORITY 3 – SUPPORT OUR PEOPLE: Reduce Sickness																
Sickness (Total)	7.6%	7.6%	7.2%	7.7%	6.7%	6.6%	6.3%	6.6%	7.2%	8.8%	8.3%	7.7%	7.6%	7.5%	7.1%	7.1%
Sickness - A&E	7.2%	7.4%	7.1%	7.2%	6.4%	6.4%	5.8%	5.9%	6.6%	8.2%	8.0%	7.2%	7.2%	7.2%	7.2%	
Sickness - EOC	7.9%	8.8%	8.5%	9.2%	6.5%	6.6%	6.0%	7.0%	7.3%	10.0%	9.6%	8.6%	9.1%	8.9%	7.5%	
Sickness - IUC	12.7%	12.0%	11.2%	11.6%	11.7%	12.0%	11.6%	10.4%	12.1%	15.9%	14.0%	13.8%	13.1%	11.7%	12.2%	
Sickness - PTS	8.0%	8.6%	7.7%	8.8%	7.5%	6.2%	6.7%	8.5%	8.0%	9.4%	7.9%	7.9%	8.7%	8.4%	7.5%	
Long Term Sickness (%)	4.21%	4.76%	4.39%	4.57 %												3.96%
Short Term Sickness (%)	3.3%	2.83%	2.86%	3.09 %												3.05%

Source: Yorkshire Ambulance Service BI Portal. All business plan performance metrics were extracted on 7-8 July 2026 and represent the latest available position at the time of reporting. Data is subject to routine validation through the Trust's performance management framework

Board of Directors (in Public)
23 July 2026

Report Title	Highlight Report from the Finance and Performance Committee
Author	Andrew Chang, Non-Executive Director
Accountable Director	Kathryn Vause, Executive Director of Finance
Previous committees/groups	None
Recommended action(s) (assurance, approval, information)	Assurance/Information
Purpose of the paper	To provide key updates from the Finance and Performance Committee meeting held on 14 May 2026 and 11 June 2026.

Executive Summary

This report summarises key updates from the Finance & Performance Committee meetings of 14 May 2026 and 11 June 2026 for the Trust Board's assurance and information.

The Committee did not have any issues of Alert for the Board from either meeting acknowledging that the Quality Committee is raising an Alert to 999 call answering performance where performance deteriorated from averaging 4 seconds in April to 13 seconds in May and that more significantly, there were over 2000 calls waiting greater than 2 minutes to be answered.

Under Advise:
From the May 2026 meeting the Committee recommended that the board approve the award of a contract for conversion of 45 Peugeot Diesel base vehicles and award of a contract for 25 Renault Electric base vehicles.
From the June meeting the Committee recommends that the board accepts and approves the Finance and Performance Annual Report.

Under Assure:
From both the May and June meetings the Committee noted the good operational performance across several metrics and the early revenue and capital financial performance.

Recommendation(s)	It is recommended that the Trust Board note the contents of the report.
Link to Board Assurance Framework Risks (board and level 2 committees only)	12. Secure sufficient revenue resources and use them wisely to ensure value for money.

Escalation and Assurance Report

Report from: Finance & Performance Committee
Date of the meetings: 14 May 2026 and 11 June 2026

Key discussion points and matters to be escalated from the discussion at the meeting:

Alert:

There are no items of Alert to make the board aware of.

Advise:

At the May meeting the Committee:

- Considered the challenges faced with 111 clinical callback times, particularly for lower-acuity patients, where waits of 6–8 hours were occurring reflecting capacity and funding constraints, with clinical prioritisation applied to ensure higher-acuity patients were responded to safely. While the position was acknowledged as delivering a poor patient experience, it was not a patient safety issue.
- Noted that staff sickness absence remains above target, despite seasonal improvement.
- Received and considered a report on the 2025/26 Business Plan performance noting that while not all objectives had been fully achieved, the Trust had taken a balanced and transparent approach to performance reporting. The Committee welcomed the maturity of approach, noting that delivery risks had been acknowledged rather than minimised. The Committee agreed that the report appropriately captures the learning from 2025/26 with shortfalls clearly identified and translated into focused credible priorities for 2026/27.
- Discussed the BAF and Corporate Risks noting that increased uncertainty and instability within councils could affect health and care partnership working.
- Received a verbal update on financial performance noting non-pay overspends, primarily linked to utilities and fuel price pressures; capital spend was behind plan, but this is due to capital expenditure being moved into Q4 of 2025/26, given access to slippage, there had been a temporary dip in Better Payment Practice Code performance in M1.
- Received a presentation on the progress regarding the Humber & North Yorkshire Patient Transport Services contract, noting that negotiation is taking longer than anticipated though agreement is expected in June. The Committee received assurance that pending contract finalisation, global sum arrangements remain in place, these include PTS income; and interim agreement has been reached that Category A and F ECRs remain payable in addition to the global sum, this is subject to future review.
- Received a report seeking endorsement of contract awards for the conversion of Patient Transport Service vehicles, comprising 45 diesel vehicles and 25 electric vehicles. Two compliant competitions had been completed. The Committee noted the procurement outcome and took assurance that the evaluation process was compliant and robust. **The Committee recommends that the board approves the award of a contract for conversion of 45 Peugeot Diesel base vehicles to Wilker UK; and award of a contract for 25 Renault Electric base vehicles to Woodall-Nicholson.**

At the June meeting the Committee:

- Received a verbal report on operational performance noting: 999 call answering performance deteriorated from averaging 4 seconds in April to 13 seconds in May, more significantly, there were over 2000 calls waiting greater than 2 minutes to be

answered; Hear & Treat rate is still behind target however encouragingly is up from 12.1% in April to 13.1% in May.

- Considered its draft Annual Report and self-assessment against compliance with its Terms of Reference. It resolved to approve the report for submission to the board and **recommends that the board accepts the Finance and Performance Annual Report and approves it.**

Assure:

At the May meeting the Committee:

- Noted that 999 Category 2 response times at their lowest level since pre-COVID, placing YAS among the best performing ambulance services nationally.
- Noted the continued reduction in excessive response times, also at pre-COVID benchmark levels. 999 call answering performance averaging approximately 4 seconds, the best since May of the previous year, albeit other service providers are averaging closer to zero to two seconds.
- Noted that 111 call handling performance showing strong improvement, with average answer times of around 30 seconds, the best since the previous summer.
- Noted the good PTS performance across key indicators, with improvement compared to the previous year.
- Received assurance that the final pay award funding now fully covers inflationary pressures.
- Was updated on a change to the timing of the deployment of the strategy for the procurement of Non-Emergency Patient Transport Services that had been approved by the Committee. This involved the issuing of a call off order for another year of service allowing for an approach to market next year. The Committee was assured that the approach being taken remains compliant and proportionate. The Committee confirmed it had no objection to the proposed 12-month delay to the procurement.
- Received and considered the Procurement strategy for the provision of End Point Assessment (EPA), which proposed a four-year contract to be procured via an open procedure. The Committee was assured that the proposed procurement route was compliant and proportionate and that the open procedure would support broader market engagement. The Committee approved the proposed Procurement strategy.

At the June meeting the Committee:

- Noted that Category 2 performance is stable and getting better; from 24:57 in May to 23:17 in June.
- Received and considered the Cyber Assurance Report and was assured that cyber security arrangements were appropriate and robust.
- Received a verbal update on the Trust's revenue financial performance expressing confidence in the Trust's ability to breakeven on the year. This took account of current cost pressures on fuel and power. The £2.2m unidentified CIPs can be covered by further reductions in expenditure that were identified in the detailed budget setting exercise. There is c. £1m underdelivery forecast in terms of cash releasing efficiencies in 2025/26. Capital is currently underspent however it is understood and not currently a concern.
- Took assurance from the Resilience Governance Group Highlight Report.

Risks discussed:

Procurement Act 640; Operational performance 627, 612, 602, 623; 724; 695; BAF 1, 5, 13, 14

New risks identified:
None

Report completed by: Andrew Chang, Committee Chair
Date: 12 June 2026

Board of Directors (in Public)
23 July 2026

Report Title	2026-27 Revised Capital Expenditure Plan
Author	Alison Lunn, Finance Business Partner
Accountable Director	Kathryn Vause, Executive Director of Finance
Previous committees/groups	Board of Directors, 26 March 2026 Trust Executive Group 17 June 2026 Finance and Performance Committee 16 July 2026
Recommended action(s) (assurance, approval, information)	Assurance/Information
Purpose of the paper	To provide the Trust Board with an update of the revised Capital Expenditure Plan for 2026-27.

Executive Summary

This paper provides an update and assurance on the Capital Expenditure Plan for 2026/27 following confirmation of the 2025/26 capital outturn and a review of the schemes previously included in the multi-year Capital Plan approved by Board on 26 March 2026.

The revised programme reflects changes arising from the final year-end position, including higher levels of work in progress being accounted for in 2025/26, additional capital funding confirmed by NHSE late in the year, and delivery issues affecting vehicle conversion schemes. As a result, uncommitted capital funds have increased by £800k, enabling further prioritised schemes to be included in the 2026/27 programme.

The main changes include reprofiling the £10m NHSE funds for the Sheffield Make Ready Hub across 2026/27 and 2027/28; deferring the 2026/27 PTS replacement programme into 2027/28; and progressing replacement of 50% of the Rapid Response Vehicle fleet in 2026/27 to mitigate operational and financial risks.

Key risks relate to timely Board and NHSE approvals, vehicle specification and conversion issues, delivery of the Sheffield Hub, and potential revenue implications where short-term lease extensions are required.

Recommendation(s)	The Trust Board are asked to note the pragmatic changes to the Capital Expenditure Plan 2026/27 that were approved at Trust Executive Group on 17 June 2026.
Link to Board Assurance Framework Risks (board and level 2 committees only)	13. Secure sufficient capital resources and use them wisely to ensure value for money.

REVISED 2026/27 CAPITAL EXPENDITURE PLAN

1.0 INTRODUCTION

1.1 A multi-year Capital Plan covering the period 2026/27 to 2029/30 was approved by Board on the 26 March 2026.

1.2 At this time, the 2025/26 financial year was not concluded and there was a great deal of uncertainty on the outturn position for capital expenditure, which impacted upon the ability to finalise an accurate capital expenditure plan for 2026/27.

1.3 Now that the 2025/26 capital position is known, the plan for 2026/27 can be finalised. This paper sets out the changes from the March plan and provides further detail on all schemes proposed for the 2026-27 Capital Programme.

2.0 BACKGROUND

2.1 The 26/27 planning round took place earlier than in previous years, with the final plan submission to NHSE taking place on the 12 February 2026.

2.2 The Trust has a number of high value capital expenditure schemes which span financial years. Significant variances arose between the forecast position for 25/26 year end (which determines the 26/27 plan) and the final 25/26 outturn. There were several factors which influenced this:

- NHSE awarded the Trust a further £4.8m of capital funds at the end of January, which led to the acceleration of some projects planned for 26/27.
- The Trusts chosen vehicle converter went into administration in early February having commenced the conversion of 41 DCAs. This also had consequences for the delivery of the next tranche of DCA chassis, which had been planned for early March. This created a high level of uncertainty however final outturn for 25/26 was more advantageous than had been anticipated at planning stage.
- Work in progress (WIP) estimates made at the planning stage for several schemes, including vehicle conversions and some estates projects were significantly different from those reported at 31 March.

2.3 As a result, a number of schemes were delayed beyond their planned completion dates and other schemes were accelerated to mitigate against potential underspends.

2.4 Several schemes scored similarly and exceeded the limit of available capital funds; further discussions were needed with capital budget holders to finalise prioritisation.

2.5 The number of movements, and the value associated with them, means it has been necessary to restate the capital plan. Uncommitted funds increased by £800k due to a higher value of WIP being accounted for in 25/26. A revised programme of capital expenditure is set out in section 4, along with explanation of key movements.

3.0 CAPITAL FUNDS

3.1 NHSE have now confirmed that the £10m fund available for a Make Ready Hub will be profiled as:

- £7m in 2026/26
- £3m in 2027/28

This was previously shown as £10m in 2026/27. Expenditure has been reprofiled to match the funding stream.

3.2 There are no other changes to capital funds. The level of capital funding is summarised below.

Funding	Status	2026/27	2027/28	2028/29	2029/30
ICB Core Allocation - Purchase & Lease	*Confirmed*	£14,275	£14,930	£15,280	£16,548
DCA Replacement (Ambulance RtCS) -Diesel	*Confirmed (business case submitted and approved)*	£9,527	£8,587	£6,354	£3,036
DCA Replacement (Ambulance RtCS) - BEV	*Confirmed (business case submitted and approved)*	£1,913	£3,734	£6,745	£9,084
Estates Safety Fund	*Confirmed*	£178	£178	£178	£178
Sale Proceeds: Wath	*Subject to sale*	£400			
Sale Proceeds: Hull fleet workshop & Sutton Fields	*Subject to sale*	£1,150			
Springhill HQ Loan repayment		-£334	-£334	-£334	-£334
RtCS Make Ready*	Confirmed (subject to short form business case)	£7,000	£3,000		
2025/26 revenue surplus		£2,500			
PLANNED CAPITAL FUNDS		£36,609	£30,095	£28,223	£28,512

** previously shown as £10m in 2026/27*

4.0 CAPITAL EXPENDITURE

4.1 Overall, the year-end position was more favourable than had been anticipated when the plan was presented to Board, and the Trust was able to account for higher levels of WIP on partially completed vehicle conversion. This meant a higher proportion of capital funds was uncommitted enabling more schemes to be included in the plan.

4.2 **PTS Replacement:**

4.2.1 In 25/26, Trust Board approved the replacement of 70 PTS vehicles. There was an expectation that the majority of this could be delivered in 25/26, however neither the diesel nor the electric vehicle conversions could be delivered and as there were no electric vehicle conversions scheduled, the base vehicle supplier deferred the chassis build.

4.2.2 The Trust had planned a further PTS replacement programme in 26/27 (subject to Board approval), however the significant slippage of the 25/26 programme meant there would be insufficient funds to account fully for the 26/27 programme. There is little benefit in planning for partial completion of PTS vehicles as it limits the Trust to a purchase-only option and removes the opportunity to lease and vehicles would not be available for operational use until early 2027/28.

4.2.3 Therefore, the 26/27 PTS replacement programme has been deferred fully into 27/28. This frees up resources for other schemes, allows the Trust to explore both lease and purchase options and, as vehicles could not be delivered before Q1 in 27/28 in any event; does not impact upon vehicle availability. It should be noted however, that the delay to the 25/26 programme has meant that expired leases on a number of vehicles have had to be extended on a short-term basis. This is financially disadvantageous to the revenue position, as short-term lease expenditure does not attract depreciation funding.

4.3 **Rapid Response Vehicles**: The Trust has 106 RRVs that were acquired under 3,4 and 5 year lease terms, with 5-years being the maximum available lease period. The 3-year leases have already been extended to 5 years. Extending the 4-year leases to 5 years would require all 106 vehicles to be replaced in 2027/28, which would cause

operational pressures for the Fleet department and require a high proportion of operational capital funds in-year, putting other high priority schemes at risk. This risk has been mitigated by planning to replace 50% of the RRV fleet in 26/27.

4.4 The detailed, revised capital expenditure plan is set out in the table below.

2026-27 Capital Expenditure Programme				2026/27 Capital Expenditure Plan (March '26 Board)	Revised 2026/27 Capital Expenditure Plan	Movement	Explanation of movement	Approval Status
Dept.	Scheme Description	Status/Score	No. Vehicles	£000s				
Fleet	c/fwd from 25/26 41 DCA conversion	Ordered	41	£ 3,000	£1,202	-£1,798	Higher WIP value at year end	Board approved
Fleet	c/fwd from 25/26 PTS (45 Diesel conversion)	Ordered	45	£ 2,015	£1,841	-£174	Favourable price variance following tender	Board approved
Fleet	c/fwd from 25/26 PTS (25 x Electric chassis & conversion)	Ordered	25	£ 1,089	£ 1,636	£547	Chassis not delivered as expected in 25/26	Board approved
Fleet	c/fwd BEV DCA (5 vehicle conversion)	Ordered	5	£ 655	£655	£0		Board approved
Fleet	c/fwd from 25/26 CBRN conversion & equipment	Ordered		£ 694	£253	-£441	Higher WIP value at year end	Board approved
Fleet	c/fwd from 25/26 Private and Event conversion	Ordered	3	£ 251	£251	£0		Board approved
Fleet	DCA Conversion (YAS6)	Pre - commitment	73	£ 7,505	£7,425	-£80	Cost of yellow paint - paid in 25/26	Board approved
Fleet	Engine replacement + staff	Pre - commitment	100	£ 1,700	£1,700	£0		Board approved
Estates	Hull Ambulance Station	Pre - commitment		£ 1,026	£2,071	£1,045	Couldn't fully complete in 25/26	Board approved
ICT	Common CAD (Project)	Pre - commitment		£ 65	£65	£0		Board approved
Fleet	Embrace Ambulance	Pre - commitment	1	£ 224	£0	-£224	Delivery expected July 2027	Board approved
ICT	ePR replatforming (999 Operations Ipads)	Pre - commitment		£ 217	£217	£0		Board approved
Estates	EV charging Infrastructure PTS	Pre - commitment		£ 395	£296	-£99	Some completed in 25/26	Board approved
Fleet	Reach Truck	Pre - commitment	1	£ 13	£13	£0		Within delegated limits
Fleet	Hull AVP Fleet uplift (5DCA + 2 RRV)	Pre - commitment	7	£ 350	£300	-£50	Some Equipment purchased in 25/26	Board approved
ICT	RPC CAD Development	Pre - commitment		£ 93	£93	£0		Board approved
Fleet	BEV DCA (10 vehicles) incl. self-loading stretchers	Ringfenced	10	£ 2,142	£2,142	£0		National programme
Estates	Estate Safety Fund	Ringfenced		£ 178	£178	£0		Within delegated limits
Estates	Make Ready Hub	Ringfenced		£ 10,000	£8,000	-£2,000	Reprofiled funds plus £1m internal funds	FBC needs Board approval
Fleet	RRV & PTS	Risk scored	70	£ 5,385		-£5,385	see detail below	
Estates	Backlog maintenance, Seacroft, Estates strategy	Risk scored		£ 1,945		-£1,945	see detail below	
ICT	AI, 111, PTS Cleric, Laptops & PCs, Servers, Network	Risk scored		£ 668		-£668	see detail below	
Estates	Renewal of existing leases - Edlington & Adwisk Le St LRP	Must do			£16	£16		Within delegated limits
Procurement	Renewal of existing lease - Trust wide Managed Print Service	Must do			£167	£167		Approved
Estates	High priority backlog maintenance	510			£700	£700		Multiple schemes - delegated limits
Estates	Seacroft	480			£400	£400		Within delegated limits
ICT	AI & innovation initiative	480			£100	£100		Within delegated limits
ICT	111 Development & GPOOH	480			£32	£32		Within delegated limits
ICT	WFM System (moving to Cloud)	480			£95	£95		Within delegated limits
ICT	PTS - Cleric system	470			£10	£10		Within delegated limits
ICT	Sso using NHSE	460			£20	£20		Within delegated limits
Fleet	RRVs	460	54		£3,159	£3,159		Requires Board approval
ICT	ICT Hardware Refresh	450			£296	£296		Within delegated limits
ICT	ICT Server Refresh	440			£200	£200		Within delegated limits
ICT	ICT Network infastructure	440			£30	£30		Within delegated limits
Fleet	Private Events 4x4	440	4		£550	£550		Requires TEG approval
Fleet	Training School Vehicles	440	3		£302	£302		Within delegated limits
ICT	Unified Comms enhancements/licences	400			£30	£30		Within delegated limits
Estates	YAS Academy - Morley 2 year lease	Efficiency plan			£373	£373		Within delegated limits
Estates	Minor works				£250	£250		Within delegated limits
Estates	EV infrastructure				£564	£564		Within delegated limits
Fleet	DCA fleet increase 12 vehicles (balance of equipment)		12		£516	£516		Requires TEG approval
All	Contingency				£461	£461		Within delegated limits
Total Capital Expenditure				£ 39,609	£ 36,609	-£ 3,000		

5.0 RISKS

5.1 There are several high value programmes of expenditure that require Trust Board approval, before orders can be raised; including PTS fleet Replacement, RRV fleet replacement and Sheffield Hub. Furthermore, 999 operations have requested a respecification of the RRV vehicle which means a like-for-like replacement cannot be considered. Failure to obtain Board approval in a timely way poses a risk to delivery in-year.

5.2 Electric Vehicles: There are issues emerging in respect of the converted vehicle weight for both the Ford and Renault base vehicle. A different base vehicle may need to be considered, which may necessitate a change to the conversion specification, requiring consultation with 999 operational colleagues. Delays in determining a suitable base vehicle and conversion, could pose a risk to delivery in-year.

5.3 Funds have been set aside to increase the size of the DCA fleet, aligned to the increased frontline staffing numbers included in the revenue plan. This will be achieved by retaining some older vehicles initially but will require an investment in additional equipment. Work to determine the required number of DCAs is being undertaken by 999 Operations. There is a risk to delivery if this is not approved in a timely way.

5.4 There are implications to the Trusts revenue position if vehicle leases have to be extended under short-term arrangements which result in higher costs that can't be offset with depreciation funding.

5.5 **Sheffield Hub**: NHSE have allocated £10m of funds for a new hub, which will be drawndown over 2 financial years. There are several risks to the delivery of this scheme.

5.5.1 A site has been identified and an offer accepted, which is subject to planning approval. If planning permission is not granted on this site, alternative locations would need to be explored. If suitable alternatives cannot be found within the required timeframe, the programme would not be able to proceed and funding may be withdrawn.

5.5.2 Multi-stage approval is required from both Trust Board and NHSE. If this is not achieved within required timeframes, the vendor may choose to withdraw from the sale and remarket the property.

5.5.3 The cost of purchasing the site and refurbishing the premises is expected to be higher than the funds from NHSE, requiring the Trust to commit some of its operational capital. These costs are not yet known. If costs become prohibitive, the project may need to be deferred/cease.

6.0 RECOMMENDATION

6.1 The Trust Board are asked to note the pragmatic changes to the Capital Expenditure Plan 2026/27 that were approved at Trust Executive Group on 17 June 2026.

Board of Directors (in Public)
23 July 2026

Report Title	Operational Performance Assurance – M3 June Update
Author	Gavin Austin, Senior Programme Lead
Accountable Director	Carol Weir, Director of Strategy, Planning and Performance
Previous committees/groups	• Trust Executive Group (15 July 2026) • Finance and Performance Committee (16 July 2026) • Trust Board (23 July 2026)
Recommended action(s)	Assurance
Purpose of the paper	To provide update on performance across all service lines and provide assurance that improvement actions are in place.

Executive Summary

This report provides assurance on Trust-wide operational performance for June 2026, focusing on key exceptions across 999 Operations, Remote Patient Care (EOC and IUC) and PTS, and reflecting the Performance Management Framework approach to monitoring improvement actions.

In 999 Operations, Category 2 mean response time deteriorated to **25 minutes 29 seconds**, which was **1 minute 39 seconds worse than plan**, with all areas below trajectory during a period affected by adverse operating conditions in the June heatwave. Key drivers included crew clear remaining materially above plan, deployed DCA and staff hours below planned levels and sickness at **7.2%**, partly offset by arrival-to-handover remaining better than trajectory and the workforce position being **59 FTE above plan**. The A&E budget position was **£549k underspent** at month 3.

In EOC, mean call answer performance worsened from **13 to 15 seconds**, below the planned level of 9 seconds, despite demand being 3.0% below forecast. The deterioration was linked to peaks in demand, call handler downtime and staffing levels. EOC appraisal compliance improved to **89.9%**, but sickness rose to **9.2%**. The budget position was **£293k underspent**.

In IUC, call answer performance reduced to **88.0%** of calls answered within 120 seconds but remained **21.6 percentage points above plan**. Clinical assessment within the agreed timeframe remained low at **9%**, with actions progressing following TEG and ELB consideration. Workforce was on plan, appraisal compliance improved to **90.1%**, and sickness remained high at **11.6%**. IUC was **£200k overspent**.

PTS activity was **5.4% below forecast**, with mixed KPI delivery: KPI 1 exceeded plan, while KPI 2, KPI 3 and KPI 4 were below plan. Call answering improved to **98.8%**. Appraisal compliance remained below target at **88.1%**, sickness increased to **7.8%**, and the service was **£133k underspent**. Overall, the report identifies continuing risks around EOC responsiveness, Hear and Treat, IUC clinical callbacks, workforce resilience and adverse operating conditions, with mitigation managed through established performance arrangements.

Recommendation(s)	The Board to note the contents of this paper for assurance purposes.
Link to Board Assurance Framework Risks (board and level 2 committees only)	1. Deliver a timely response to patients. 2. Provide acces to appropriate care. 3. Support patient flow across the urgent and emergency care system.

1.0 INTRODUCTION

1.1 This report presents the key exceptions in operational performance to support focused improvement action. It provides assurance on the delivery of performance across all service lines and reflects the discussions and agreed actions from the monthly Executive led Performance Review and Improvement meetings, chaired by the Chief Paramedic. These meetings form a core part of the Performance Management Framework (PMF), which supports the Trust to plan, monitor and deliver high quality patient care. Each operational area presents its operational, financial and workforce performance, and the resulting updates and exception commentary inform both ongoing improvement work and quarterly Business Plan reporting.

2.0 BACKGROUND

2.1 Data is provided from the Operational Trajectory[1] and Integrated Performance Report[1] dashboards which are part of a suite of performance and assurance reports to support monitoring processes, identify performance challenges and improvement opportunities and assess the effectiveness of recovery actions. These reports include both key outputs (e.g. call demand, Cat 2 performance) and inputs (e.g. deployed ambulance hours, workforce numbers.

2.2 The latest available NHS Oversight Framework metrics table (Q4 2025-26 published 11/6/26) is also included as an appendix (see Table 3).

3.0 OPERATIONAL PERFORMANCE ASSURANCE

3.1 The performance overview in this report is broken into the three operational areas of: 999 Operations, Remote Patient Care (EOC and IUC) and PTS. The measures cover the agreed metrics and targets from the Trust business plan.

3.2 999 OPERATIONS

3.2.1 **Category 2 mean** response time in June was 25 minutes 29 seconds, an increase on the previous month and 1 minute 39 seconds worse than trajectory target. June performance coincided with a significant national heatwave between 22 and 26 June 2026, during which England experienced record-breaking temperatures and health service providers operated under elevated heat-health alerts. YAS activated adverse weather arrangements and increased escalation measures in response to the forecast pressures, which may have contributed to increased demand and operational pressures affecting response times.

3.2.2 All areas performed below plan during June, reflecting the impact of challenging operating conditions, although variation across regions remained evident. HNY and the West remained relatively close to trajectory at 6 seconds and 34 seconds worse than plan respectively, while performance in the South was further from plan, with response times 2 minutes and 13 seconds slower than expected.

3.2.3 The key drivers and improvement actions for Category 2 response times are as follows:

- **Crew clear** time was up marginally in June, rising by 9 seconds to 22 minutes 13 seconds. Performance remains worse than planned trajectory at 3 minutes 17 seconds higher than plan. It should be noted the target was established in

[1] Links to most recently published Power BI dashboard/report

November based on the level of improvement seen earlier in 2025/26. Performance deteriorated during Q4, ending the year worse than plan, resulting in a requirement for a significant improvement of approximately three minutes between Q4 and Q1 to return to trajectory.

- **Arrival to handover** increased by 1 minute 4 seconds compared to the previous month, to 18 minutes 1 second, which is better than the trajectory plan. South Yorkshire continues to deliver the strongest performance, recording an average of 15 minutes 29 seconds in June.

- **Deployed average daily hours** on DCA's were 5,687 hours in June, 1.0% below plan, and average daily staff hours were 11,956, 0.6% below plan; both measures are below planned levels, indicating reduced operational capacity which can impact response times. Action is being taken to address this in June through use of targeted overtime.

- **Sickness** absence in A&E increased slightly from 7.1% to 7.2% in June and was 1.2pp above plan. Sickness above plan is the main contributing factor to deployed hours being below plan. The June heatwave may also have been a contributory factor to the increase in sickness absence, placing additional strain on staff working in challenging operational conditions.

- **Excessive responses (twice the 90th percentile)**
  Cat 2 excessive responses rose by 340 (40.7%) vs last month but fell by 126 (-9.7%) vs May 2025. They accounted for 3.3% of Category 2 responses on scene in 2026 (3.9% last year).
  - HNY had the lowest rate at 2.9% (300) of Category 2 responses
  - SY had the highest rate stood at 3.2% (339) of Category 2 responses
  - West rate was 3.1% (537) of Category 2 responses

3.2.4 **999 Workforce** position was above plan in June by 59 FTE (1.7% above trajectory). The current year end position is forecast to be 9 FTE above plan.

A&E											
JUNE 2026						YEAR END FORECAST @ 8/7/26					
TOTAL FTE				SUBSTANTIVE FTE	OVERTIME FTE	TOTAL FTE				SUBSTANTIVE FTE	OVERTIME FTE
OPERATING PLAN	ACTUAL	FTE Variance against this month's Plan		Variance against this month's Plan		OPERATING PLAN	FORECAST	FTE Variance against Year End Plan		Variance against Year End Plan	
		No	%	%	%			No	%	%	%
3,374	3,433	59	1.7	+1.2%	+39.6%	3,403	3,411	8	0.24	+1.10%	-31.2%

3.2.5 **Appraisal compliance** fell slightly from 89.6% to 89.0% in June which is slightly under the 90% planned target.

3.2.6 **Budget** position at month 3 is £549k underspent.

3.3 **REMOTE CARE**

3.3.1 **EOC**

3.3.2 **Mean call answer** performance worsened from 13 to 15 seconds in June, underperforming against the planned level of 9 seconds. Demand was below plan at

3.0% lower than the forecasted daily average (96 fewer calls) However significant peaks on day which exceeded capacity along with call handler downtime being higher than optimum levels contributed to the drop in performance. While call handler workforce was above plan, staffing levels within EOC dispatch and clinical teams remained slightly below plan.

The current year end position is forecast to be slightly below plan.

EOC											
JUNE 2026						YEAR END FORECAST @ 8/7/26					
TOTAL FTE				SUBSTANTIVE FTE	OVERTIME FTE	TOTAL FTE				SUBSTANTIVE FTE	OVERTIME FTE
OPERATING PLAN	ACTUAL	FTE Variance against this month's Plan		Variance against this month's Plan		OPERATING PLAN	FORECAST	FTE Variance against Year End Plan		Variance against Year End Plan	
		No	%	%	%			No	%	%	%
EOC CALL HANDLING											
243	254	11	4.3	+2.20%	83.5%	264	263	-1	-0.38	-0.30%	+57.1%
EOC DESPATCH											
142	130	-12	-9.2	-8.10%	-25.0%	139	137	-2	-1.46	-1.60%	-14.3%
EOC CLINICAL											
151	144	-7	-4.9	-2.2%	-14.3%	167	163	-4	-2.45	-2.5%	-12.5%

3.3.3 **People Measures**

- **Appraisal compliance** in EOC improved from 88.2% to 89.9% in June which is almost in line with the 90.0% year-end target and requires continued focus to improve compliance.
- **Sickness** increased from 8.6% to 9.2% which was 3.2 pp above the 6.0% trajectory for June. Existing support for colleagues continues from the wellbeing team in EOC.

3.3.4 **Budget** position was £293k underspent at month 3.

3.4 **IUC**

3.4.1 Call answer performance in June worsened on the previous month from 92.6% of calls answered in 120 seconds to 88.0% but was 21.6 pp above plan for June. Demand in June was 3.7% below plan (197 calls). The key drivers and actions that impact on call answer are as follows:

- **Proportion of calls assessed by a clinician within agreed timeframe** remained low at 9%. A paper on reporting options went to TEG in June and then onto ELB at the end of June detailing what codes are included in reporting and actions continue to be progressed to improve performance.
- **Workforce position** was exactly on plan in June for both Health and Clinical Advisors.

IUC											
JUNE 2026						YEAR END FORECAST @ 8/7/26					
TOTAL FTE				SUBSTANTIVE FTE	OVERTIME FTE	TOTAL FTE				SUBSTANTIVE FTE	OVERTIME FTE
OPERATING PLAN	ACTUAL	FTE Variance against this month's Plan		Variance against this month's Plan		OPERATING PLAN	FORECAST	FTE Variance against Year End Plan		Variance against Year End Plan	
		No	%	%	%			No	%	%	%

HEALTH ADVISERS											
408	408	0	0.0	-18.8%	-49.3%	424	426	2	0.47	+1.2%	NA
CLINICAL ADVISERS											
116	116	0	0.0	-0.90%	-20.0%	125	125	0	0.00	0.0%	-14.3%

3.4.2 **People Measures**

- **Sickness** in IUC rose slightly from 11.4% to 11.6% in June and is 1 pp above plan. Sickness reduction continues to be a key focus, with plans to implement actions successfully applied within EOC to support further improvement in 2026/27.
- **Appraisal** compliance improved in June from 89.1% to 90.1% and is above the 90% Trust target.

3.4.3 **Budget** IUC position at month 3 is £200k overspent

3.5 **PTS**

3.5.1 Patient Transport Service (PTS) activity in June was below forecast by 5.4%, falling marginally out of the 5.0% threshold. 8,268 extra contractual journeys (ECJ) were delivered against a plan of 8,631, representing a 4.2% reduction against plan. Category F (non-eligible patient travelling to systemic anti-cancer treatment or radiotherapy) journeys accounted for 48.9% of total Extra Contractual Referrals (chargeable journey not in the core contract), this was consistent with the with April and May.

Metric	Actual June 26	Variance against Plan
KPI 1 – Pickup / Journey Time	97.2%	+5.9 pp
KPI 2 – Dropoff / Arrival Time	85.4%	-2.2pp
KPI 3 – Pre-Planned: At Location in 90m %	90.2%	-0.3pp
KPI 4 – Short Notice: At Location in 120m %	81.5%	-6.8pp

3.5.2 The drivers and actions to improve are as follows:

- **Demand** averaged 2,230 journeys per day in June, 5.4% below plan. Regionally, activity remained below trajectory across all areas, with South 3.6%, HNY 3.5% and WY 7.8% below plan, indicating lower-than-expected demand.
- **Patients per vehicle (PPV)** decreased to 1.36 in June and is being closely monitored since eligibility go live as we aim to maximise the efficiency of our own vehicles to achieve planned savings.
- **Workforce position** was slightly above plan in June and is forecast to be 1.5% below operating plan forecast at the year end.

PTS											
JUNE 2026						YEAR END FORECAST @ 8/7/26					
TOTAL FTE				SUBSTANTIVE FTE	OVERTIME FTE	TOTAL FTE				SUBSTANTIVE FTE	OVERTIME FTE
OPERATING PLAN	ACTUAL	FTE Variance against this month's Plan		Variance against this month's Plan		OPERATING PLAN	FORECAST	FTE Variance against Year End Plan		Variance against Year End Plan	
		No	%	%	%			No	%	%	%
465	470	5	1.1	+0.60%	+6.20%	465	458	-7	-1.53	-0.90%	-9.90%

3.5.3 **Call answering** performance (within 180 seconds) was up from 96.0% to 98.8% in June.

3.5.4 **People Measures**

- **Appraisal** compliance stood at 88.1% in June which was below the target of 90%.
- **Sickness** rose by 1pp to 7.8%, which was 2.4pp worse than the June operating plan trajectory. Support measures remain in place, and work is underway to identify suitable alternative duties for PTS staff.

3.5.5 **Budget** position is £133k underspent at month 3

4.0 FINANCIAL IMPLICATIONS

4.1 Overall, operation budgets are £775k underspent against plan at month 3, but remain forecast at break even for the year.

5.0 RISKS

5.1 Key risks arising from this report are:

- **EOC mean call answer:** Forecasted shortfalls in recruitment numbers in July and August are likely to further impact call performance over coming months.
- **Risk to patient experience and system confidence (Hear and Treat):** Even though we have seen a marked improvement, there continues to be an underperformance in Hear and Treat, linked to NHS Pathways implementation, this may increase responses at scene as has been seen through the last 12 months.
- **Risk to patient experience and system confidence (IUC clinical callbacks):** low performance in IUC clinical callbacks (KPI4), driven by increased demand and constrained clinical capacity, may continue without additional investment and could adversely impact patient experience.
- **Workforce resilience risk:** elevated sickness levels in some operational areas may reduce resilience, increase pressure on available staff, and impact the Trust's ability to sustain operational performance.
- **Sustained periods of adverse operating conditions**, including extreme weather events, may further impact operational performance, workforce wellbeing and service resilience.

5.2 **Mitigation and oversight:** these risks are recognised and are being actively managed through targeted improvement actions, workforce planning and financial controls, with ongoing monitoring and escalation through the established performance management arrangements.

6.0 RECOMMENDATIONS

6.1 The Board are asked to note the contents of this paper for assurance purposes.

APPENDIX 1 – WORKFORCE PERFORMANCE TRAJECTORIES

TABLE 1: WORKFORCE POSITION – JUNE 2026 AND 2026/27 YEAR END FORECAST

OPERATIONAL SERVICE AREA	JUNE 2026						YEAR END FORECAST @ 8/7/26					
	TOTAL FTE				SUBSTANTIVE FTE	OVERTIME FTE	TOTAL FTE				SUBSTANTIVE FTE	OVERTIME FTE
	OPERATING PLAN	ACTUAL	FTE Variance against this month's Plan		Variance against this month's Plan		OPERATING PLAN	FORECAST	FTE Variance against Year End Plan		Variance against Year End Plan	
			No	%	%	%			No	%	%	%
A&E Operations	3,374	3,433	59	1.7	+1.2%	+39.6%	3,403	3,411	8	0.24	+1.10%	-31.2%
EOC Call Handling	243	254	11	4.3	+2.20%	83.5%	264	263	-1	-0.38	-0.30%	+57.1%
EOC Despatch	142	130	-12	-9.2	-8.10%	-25.0%	139	137	-2	-1.46	-1.60%	-14.3%
EOC Clinical	151	144	-7	-4.9	-2.2%	-14.3%	167	163	-4	-2.45	-2.5%	-12.5%
IUC HA	408	408	0	0.0	-18.8%	-49.3%	424	426	2	0.47	+1.2%	NA
IUC CA	116	116	0	0.0	-0.90%	-20.0%	125	125	0	0.00	0.0%	-14.3%
PTS	465	470	5	1.1	+0.60%	+6.20%	465	458	-7	-1.53	-0.90%	-9.90%
Total	**4,899**	**4,955**	56	1.1			**4,987**	**4,983**	-4	-0.08		

Source: Trajectory Report, YAS BI Portal, data 8/7/26

TABLE 2: KEY METRICS – ANNUAL BUSINESS PLAN 2026/27

		ACTUAL			FORECAST											
Metric	BASELINE (25/26 YE ave)	Apr-26	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-26	Feb	Mar	26/27 YE Forecast	YE Operating Plan	YE BP Target
STRATEGIC PRIORITY 1 – RIGHT RESPONSE: Increase Hear and Treat and reduce ED Conveyance																
Hear & Treat %	13.4%	12.1%	13.1%	14.0%	12.6%	13.2%	14.8%	15.9%	18.6%	16.1%	20.5%	20.0%	19.4%	15.9%	15.5%	15.4%
ED Conveyance Rate	52.8%	53.4%	52.3%	51.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			51.5%
Conveyance Rate		60.3%	59.0%	58.5%	60.0%	59.7%	58.6%	57.8%	55.9%	57.7%	54.4%	54.8%	55.3%	57.6%	58.30%	
Average Daily Responses at Scene	2,157	2,159	2,173	2,172	2,233	2,067	2,080	2,128	2,136	2,315	2,120	2,083	2,066	2,144	2,180	
STRATEGIC PRIORITY 2 – IMPROVE OPERATIONAL PRODUTIVITY & PERFORMANCE: Improve Performance including Category 2																
Category 2 Mean	00:26:14	00:22:27	00:23:57	00:25:29	00:29:40	00:22:40	00:27:25	00:29:13	00:27:13	00:25:31	00:18:52	00:28:41	00:31:20	00:26:02	00:24:44	00:24:44
Handover to Clear	00:21:53	00:22:11	00:22:04	00:22:13	00:22:21	00:22:21	00:22:21	00:22:21	00:22:21	00:22:21	00:22:21	00:22:21	00:22:21	00:22:18	00:19:03	00:19:05
Arrive to Handover	00:19:14	00:17:28	00:17:57	00:18:01	00:19:35	00:17:20	00:18:09	00:18:04	00:20:10	00:21:13	00:20:58	00:19:45	00:18:44	00:19:03	00:19:23	
Vehicle Availability: DCA	80.2%	81.8%	79.6%	81.6%												
IUC Not Ready Reason Codes – Health Advisor	28.00%	28.20%	28.20%	28.00%	28.00%	28.00%	28.00%	28.00%	28.00%	28.00%	28.00%	28.00%	29.00%	28.00%		
IUC Clinical Call Backs in 1 hour	41.30%	27.40%	26.60%	24.90%	27.4%	26.6%	24.9%	25.5%	26.5%	26.4%	27.0%	26.3%	24.6%	23.0%		
PTS KPI 1 deliver journey times less than 120 mins	97.10%	96.80%	97.40%	97.2%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	97.20%	91.30%	
PTS KPI 3 deliver pre planned pick up within 90 mins	89.50%	90.0%	90.4%	90.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	90.2%	90.50%	
PTS KPI 4 Deliver short notice pick up within 120 mins	80.10%	82.4%	80.7%	81.5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	81.50%	88.30%	
PTS patients per vehicle	1.38	1.37	1.37	1.36	1.39	1.41	1.39	1.37	1.41	1.44	1.39	1.41	1.43	1.37	1.36	
PTS Call Handling - answered in 180 seconds	88.00%	88.01%	96.00%	98.8%											90%	
STRATEGIC PRIORITY 3 – SUPPORT OUR PEOPLE: Reduce Sickness																
Sickness (Total)	7.6%	7.6%	7.2%	7.7%	6.7%	6.6%	6.3%	6.6%	7.2%	8.8%	8.3%	7.7%	7.6%	7.5%	7.1%	7.1%
Sickness - A&E	7.2%	7.4%	7.1%	7.2%	6.4%	6.4%	5.8%	5.9%	6.6%	8.2%	8.0%	7.2%	7.2%	7.2%	7.2%	
Sickness - EOC	7.9%	8.8%	8.5%	9.2%	6.5%	6.6%	6.0%	7.0%	7.3%	10.0%	9.6%	8.6%	9.1%	8.9%	7.5%	
Sickness - IUC	12.7%	12.0%	11.2%	11.6%	11.7%	12.0%	11.6%	10.4%	12.1%	15.9%	14.0%	13.8%	13.1%	11.7%	12.2%	
Sickness - PTS	8.0%	8.6%	7.7%	8.8%	7.5%	6.2%	6.7%	8.5%	8.0%	9.4%	7.9%	7.9%	8.7%	8.4%	7.5%	
Long Term Sickness (%)	4.21%	4.76%	4.39%	4.57%												3.96%
Short Term Sickness (%)	3.3%	2.83%	2.86%	3.09%												3.05%

Source: Yorkshire Ambulance Service BI Portal. All business plan performance metrics were extracted on 7-8 July 2026 and represent the latest available position at the time of reporting. Data is subject to routine validation through the Trust's performance management framework

TABLE 3: NHS OVERSIGHT FRAMEWORK METRICS TABLE

This table presents a set of key performance metrics used to assess the Trust's performance across several domains, as required by the NHS Oversight Framework. Each metric is reported with its value, unit, score, rank (out of 10), and the average value for comparison. Key insights:

- The Trust performs well in staff engagement and advocacy (ranked 1 out of 10).
- Response times they remain better than the average (rank 3/10).
- Sickness absence increased slightly in Q4 but remains a key focus for improvement.
- Financial metrics are stable, with no planned deficit and minimal variance to plan.

Quarter	Segment	Trust in financial deficit?
Q4 2025/26	1 - High performing	No

Domain	Sub-domain	Metric description	Release Frequency	Metric Value	Q4 2025/26					
					Reporting Date	Metric Value	Average value	Metric value change	Metric score	Rank out of 10
Access to services	Urgent and emergency care	Average Category 2 ambulance response time	Monthly	mins	To Mar 2026	26.25	28.93	-0.33 ↑	1.00	3
Effectiveness and experience	Effective out of hospital care	Percentage of ambulance patients conveyed to emergency departments	Monthly	%	To Mar 2026	52.9	48.70	0.20 ↓	3.40	9
	Patient experience	NHS staff survey advocacy score	Annual	out of 10	2025	6.67	6.1	0.09↑	1.00	1
Finance and Productivity	Finance	Planned surplus/deficit	Annual plan	%	2025/26	0.00	0.00	0.00 →	1.00	2
		Variance year-to-date to financial plan	Year to date	%	Month 12 2025/26	0.54	0.59	-0.14 ↓	1.00	6
		Combined finance	Year to date	score	Q3 2025/26				1.00	
	Productivity	Relative difference in costs	Annual	%	2024/25	96.71	96.16	0.00 ↓	1.99	6
Patient safety	Patient safety	NHS Staff survey – raising concerns sub-score	Annual	out of 10	2025	6.27	5.94	0.14 ↑	1.00	1
People and workforce	Retention and culture	Sickness absence rate	available monthly - Quarterly aggregated monthly figures	%	Q3 2025/26	8.03	7.74	0.99 ↓	3.91	7
		NHS staff survey engagement theme	Annual	out of 10	2025	6.29	5.91	0.06↑	1.00	1

Source: NHS England, 11/06/26

Board of Directors (in Public)
23 July 2026

Report Title	Operational Performance Assurance – M2 May Update
Author	Gavin Austin, Senior Programme Lead Carol Weir, Director of Strategy, Planning and Performance
Accountable Director	Carol Weir, Director of Strategy, Planning and Performance
Previous committees/groups	• Trust Executive Group (17 June 2026) • Quality Committee (9 July 2026) • Finance and Performance Committee (16 July 2026) – verbal report to 11 June 2026 meeting. • Trust Board Meeting (23 July 2026)
Recommended action(s)	Assurance
Purpose of the paper	To provide update on performance across all service lines and provide assurance that improvement actions are in place.

Executive Summary

This report provides assurance on Trust-wide operational performance for May 2026, focusing on key exceptions across **999 Operations**, **Remote Patient Care (EOC and IUC)** and **PTS**, and reflecting discussions from the Performance Review and Improvement Group.

In 999 Operations, Category 2 response time improved slightly to **23:57** and remained ahead of plan overall, although some regional variation persists and South Yorkshire performed less well. Key pressures remain for crew clear time, deployed hours below plan and sickness absence above target, partly offset by strong arrival-to-handover performance, appraisal compliance slightly below 90% target, staffing marginally above plan and a **£733k** underspend.

In EOC, mean call answer performance deteriorated significantly from **4 to 13** seconds, despite demand being slightly below plan. Hear and Treat improved markedly to **13.1%** but remained below target, with recruitment expected to support recovery later in the year. IUC performed more positively, with **92.6%** of calls answered within 120 seconds, well above plan, though sickness remains high. IUC overspent by £56k to plan.

PTS activity was below forecast, with mixed KPI delivery (KPI2 **86.4%** failing to meet target). Call answering remained strong. Staffing numbers are slightly above plan, and appraisal compliance remains below target. Overall, the financial position is below plan with workforce resilience, EOC responsiveness, Hear and Treat and IUC clinical callback performance remaining as key risks requiring continued management.

Recommendation(s)	The Board are asked to note the contents of this paper for assurance purposes.
Link to Board Assurance Framework Risks (board and level 2 committees only)	1. Deliver a timely response to patients. 2. Provide acces to appropriate care. 3. Support patient flow across the urgent and emergency care system.

1.0 INTRODUCTION

1.1 This report presents the key exceptions in operational performance to support focused improvement action. It provides assurance on the delivery of performance across all service lines and reflects the discussions and agreed actions from the monthly Executive led Performance Review and Improvement meetings, chaired by the Chief Paramedic. These meetings form a core part of the Performance Management Framework (PMF), which supports the Trust to plan, monitor and deliver high quality patient care. Each operational area presents its operational, financial and workforce performance, and the resulting updates and exception commentary inform both ongoing improvement work and quarterly Business Plan reporting.

2.0 BACKGROUND

2.1 Data is provided from the Operational Trajectory[1] and Integrated Performance Report[1] dashboards which are part of a suite of performance and assurance reports to support monitoring processes, identify performance challenges and improvement opportunities and assess the effectiveness of recovery actions. These reports include both key outputs (e.g. call demand, Cat 2 performance) and inputs (e.g. deployed ambulance hours, workforce numbers.

2.2 The latest available NHS Oversight Framework metrics table (Q4 2025-26 published 11/6/26) is also included as an appendix (see Table 3).

3.0 OPERATIONAL PERFORMANCE ASSURANCE

3.1 The performance overview in this report is broken into the three operational areas of: 999 Operations, Remote Patient Care (EOC and IUC) and PTS. The measures cover the agreed metrics and targets from the Trust business plan.

3.2 999 OPERATIONS

3.2.1 **Category 2 mean** response time in May was 23 minutes 57 seconds, representing an increase on the previous month but was 49 seconds better the trajectory target. Regional variation was evident, with the West delivering strong performance at 3 minutes 11 seconds better than plan, along with HNY better than plan by 1 minute 11 seconds. Performance was more challenging in the South where the response time was 41 seconds worse than plan.

3.2.2 The key drivers and improvement actions for Category 2 response times are as follows:

- **Crew clear** time in May improved slightly by 9 seconds, falling to 22 minutes and 02 seconds. However, this is 3 minutes and 02 seconds worse than the May trajectory. It is unlikely that crew clear trajectory will be achieved over Q1 as this was set in November based on improvements seen up to this point of the year. However, over Q4 crew clear times deteriorated finishing the year worse than plan and requiring a significant improvement of around 3 minutes from Q4 to Q1.

- **Arrival to handover** increased by 30 seconds compared to the previous month, to 17 minutes 58 seconds, but remains 1 minutes 36 seconds better than the

[1] Links to most recently published Power BI dashboard/report

May trajectory target. South Yorkshire continues to deliver the strongest performance, recording an average of 15 minutes 35 seconds in May.

- In May, **Hear and Treat** performance improved from 12.1% in the previous month to 13.1%, but remaining below the 13.4% target in May. The underlying causes and the actions being implemented to improve Hear and Treat are set out in Section 4.1.2 (Remote Care).

- **Deployed average daily hours** on DCA's were 5,673 hours in May, 2.8% below plan, and average daily staff hours were 11,911, 2.4% below plan; both measures are below planned levels, indicating reduced operational capacity which can impact response times. Action is being taken to address this in June through use of targeted overtime.

- **Sickness** absence in A&E reduced slightly from 7.4% to 7.1% in May, indicating signs of improvement; however, rates remain above the planned level by 0.7pp. Sickness above plan is the main contributing factor to deployed hours being below plan.

- **Excessive responses (twice the 90th percentile)**
  Cat 2 excessive responses rose by 176 (21%) vs last month and fell by 289 (-25.6%) vs May 2025. They accounted for 3.3% of Category 2 responses on scene in May 2026 (3.9% last year).
  - South had the joint lowest rate at 2.0% (223) of Category 2 responses
  - HNY had the highest rate stood at 2.3% (254) of Category 2 responses
  - West had the joint lowest rate at 2.0% (359) of Category 2 responses

3.2.3 **999 Workforce** position was above plan in May by14 FTE (0.41% above trajectory).

A&E OPERATIONS											
MAY 2026						YEAR END 26/27 FORECAST					
Substantive FTE Variance	OT FTE Variance	TOTAL FTE ACTUAL	TOTAL FTE OP PLAN	FTE Month Variance against Plan	%	Substantive FTE Variance	OT FTE Variance	Total FTE YE Forecast	TOTAL FTE YE OP PLAN	FTE Year End Variance against Plan	%
0.00%	-26.40%	3,417	3,403	14	0.41%	0.80%	-12.60%	3,442	3,403	39	1.15%

3.2.4 **Appraisal compliance** fell slightly from 90.6% to 89.9% in May, slightly under the 90% planned target.

3.2.5 **Budget** position at month 2 is £733k underspent.

3.3. **REMOTE CARE**

3.3.1 **EOC**

3.3.2 **Mean call answer** performance decreased from 4 seconds to 13 seconds in May, under performing against the planned level of 4 seconds. Demand was below plan at 1.0% lower than the forecasted daily average (33 fewer calls). While call handler workforce was above plan, staffing levels within EOC dispatch and clinical teams remained slightly below plan.

EOC											
MAY 2026						YEAR END 26/27 FORECAST					
Substantive FTE Variance	OT FTE Variance	TOTAL FTE ACTUAL	TOTAL FTE OP PLAN	FTE Month Variance against Plan	%	Substantive FTE Variance	OT FTE Variance	Total FTE YE Forecast	TOTAL FTE YE OP PLAN	FTE Year End Variance against Plan	%
EOC CALL HANDLING											
3.40%	-58.80%	251	246	5	2.03%	1.10%	-15.60%	267	264	3	1.14%
EOC DESPATCH											
-9.00%	-12.30%	131	143	-9	-6.29%	-2.10%	-22.40%	133	139	-6	-4.32%
EOC CLINICAL											
-3.20%	-25.00%	140	146	-6	-4.11%	-3.70%	-35.50%	160	167	-7	-4.19%

3.3.3 The **Hear and Treat** rate improved from 12.1% in the previous month to 13.1%, remaining 0.3 percentage points worse than target. Significant recruitment is planned over 26/27 with improving rates expected from September as recruited clinicians from Q1 complete training and increase competency.

3.3.4 **People Measures**

- **Appraisal compliance** in EOC improved from 84.7% in April to 88.2% in May against the 90.0% year-end target and requires continued focus to improve compliance.
- **Sickness** decreased from 8.8% to 8.5% narrowing the gap to 3.1 pp above the 5.4% trajectory for May. Existing support for colleagues continues from the wellbeing team in EOC.

3.3.5 **Budget** position was £181k underspent at month 2.

3.4 **IUC**

3.4.1 Call answer performance in May improved on the previous month from 92.2% of calls answered in 120 seconds to 92.6% and is now 10.0 pp above plan for May. Demand in May was 7.2% below plan (415 calls). The key drivers and actions that impact on call answer are as follows:

- **Call assessed by a clinician within agreed timeframe KPI4 data** was not available at the time of writing
- **Workforce** position was above plan in May by 9 FTE (2.2% above trajectory) for Health Advisors and 2 FTE (1.7% above trajectory) above plan for Clinical Advisors.

IUC											
May 2026						YEAR END 26/27 FORECAST					
Substantive FTE Variance	OT FTE Variance	TOTAL FTE ACTUAL	TOTAL FTE OP PLAN	FTE Month Variance against Plan	%	Substantive FTE Variance	OT FTE Variance	Total FTE YE Forecast	TOTAL FTE YE OP PLAN	FTE Year End Variance against Plan	%
IUC HA											
3.70%	-24.50%	403	394	9	2.28%				424		
IUC CA											
0.97%	-11.10%	116	114	2	1.75%				125		

3.4.2 **People Measures**

- **Sickness** in IUC improved from 12.0% to 11.2% in May, demonstrating a positive trajectory; however, it remains 0.6 percentage points above plan of 10.6%. Sickness reduction continues to be a key focus, with plans to implement actions successfully applied within EOC to support further improvement in 2026/27.
- **Appraisal** compliance decreased in May from 90.1% to 89.1% falling 0.9 percentage points below the 90% Trust target.

3.4.3 **Budget** IUC position at month 2 is £56k overspent

3.5 **PTS**

3.5.1 Patient Transport Service (PTS) activity in May was below forecast, with 8,571 enhanced care response journeys delivered against a plan of 9096, representing a 5.8% reduction against plan. Activity mix varied, with Category F (non eligible patient travelling to systemic anti-cancer treatment or radiotherapy) journeys accounting for 48.4% of total Extra Contractual Referrals (chargeable journey not in the core contract) and performing above forecast, indicating a shift in demand composition. Quality assurance activity commenced during the month, with initial observations across North Yorkshire sites identifying no areas of concern and supporting ongoing improvement and CQC readiness. Overall, performance reflects stable delivery with some variance against planned activity levels, alongside continued focus on quality assurance and service development

Metric	Actual May 26	Variance against Plan
KPI 1 – Pickup / Journey Time	96.0%	+2.0%
KPI 2 – Dropoff / Arrival Time	87.9%	+3.9%
KPI 3 – Pre-Planned: At Location in 90m %	89.0%	-2.5%
KPI 4 – Short Notice: At Location in 120m %	77.0%	-8.0%

3.5.2 The drivers and actions to improve are as follows:

- **Demand** averaged 2,061 journeys per day in May, 11.8% below plan, indicating activity lower than expected. Regionally, performance was 16.4% below plan in the South (better than plan), while HNY was 10.0% below the monthly trajectory and WY 11.1% below the monthly trajectory, indicating slightly higher-than-planned activity.
- **Patients per vehicle (PPV)** remained at 1.4 in May PPV is being closely monitored since eligibility go live as we aim to maximise the efficiency of our own vehicles to achieve planned savings.

PTS											
May 2026						YEAR END 26/27 FORECAST					
Substantive FTE Variance	OT FTE Variance	TOTAL FTE ACTUAL	TOTAL FTE OP PLAN	FTE Month Variance against Plan	%	Substantive FTE Variance	OT FTE Variance	Total FTE YE Forecast	TOTAL FTE YE OP PLAN	FTE Year End Variance against Plan	%
	-12.9%	471	465	6	-1.29%				465		

3.5.3 **Call answering** performance (within 180 seconds) was up significantly from 88.0% to 96.0% in May.

3.5.4 **People Measures**

- **Appraisal** compliance dipped slightly by 0.9pp from 89.5% in April to 88.6% in May which is below the target of 90%.
- **Sickness** fell by 0.9pp to 7.7%, which is 1.8pp worse than the May operating plan trajectory. Support measures remain in place, and work is underway to identify suitable alternative duties for PTS staff.

3.5.5 **Budget** position is £50k overspent at month 2

4.0. FINANCIAL IMPLICATIONS

4.1 Position is broadly in line with plan at month 2.

5.0. RISKS

5.1 Key risks arising from this report are:

- **Risk to patient experience and system confidence (Hear and Treat):** Even though we have seen a marked improvement, there continues to be an underperformance in Hear and Treat, linked to NHS Pathways implementation, may increase responses at scene as has been seen through the last 12 months.
- **Risk to patient experience and system confidence (IUC clinical callbacks):** low performance in IUC clinical callbacks (KPI4), driven by increased demand and constrained clinical capacity, may continue without additional investment and could adversely impact patient experience.
- **Workforce resilience risk:** elevated sickness levels in some operational areas may reduce resilience, increase pressure on available staff, and impact the Trust's ability to sustain operational performance.
- **EOC mean call answer:** This remains challenging with call handler numbers planned to increase by 40FTE by the end of Q2. If this is not achieved call answer performance may be impacted and remain below plan.

5.2 Mitigation and oversight: these risks are recognised and are being actively managed through targeted improvement actions, workforce planning and financial controls, with ongoing monitoring and escalation through the established performance management arrangements.

6.0. RECOMMENDATIONS

6.1 The Board are asked to note the contents of this paper for assurance purposes.

APPENDIX 1 – PERFORMANCE TRAJECTORIES

TABLE 1: WORKFORCE POSITION – May 2026 AND 2026/27 YEAR END FORECAST

Source: Trajectory Report, YAS BI Portal, data 09/06/26

	Jun-26						YEAR END 26/27 FORECAST					
	Substantive FTE Variance	Overtime FTE Variance	TOTAL FTE ACTUAL	TOTAL FTE OPERATING PLAN	FTE Month Variance against Plan	%	Substantive FTE Variance	Overtime FTE Variance	Total FTE YE FORECAST	TOTAL FTE YE OPERATING PLAN	FTE Year End Variance against Plan	%
A&E Operations	0.00%	-26.40%	3,417	3,403	14	0.41%	0.80%	-12.60%	3,442	3,403	39	1.15%
EOC Call Handling	3.40%	-58.80%	251	246	5	2.03%	1.10%	-15.60%	267	264	3	1.14%
EOC Despatch	-9.00%	-12.30%	131	143	-9	-6.29%	-2.10%	-22.40%	133	139	-6	-4.32%
EOC Clinical	-3.20%	-25.00%	140	146	-6	-4.11%	-3.70%	-35.50%	160	167	-7	-4.19%
IUC HA	3.70%	-24.50%	403	394	9	2.28%				424		
IUC CA	0.97%	-11.10%	116	114	2	1.75%				125		
PTS		-12.90%	471	465	6	1.29%		-10.80%	460	465	-5	-1.08%
Total			**4,929**	**4,911**	**7**	**-2.63%**				**4,987**		

TABLE 2: KEY METRICS PERFORMANCE TABLE

Metric	BASELINE (25/26 YE ave)	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 26	Feb	Mar	Apr	May	YE Forecast	YE Operating Plan
Category 2 Mean	00:26:14	00:25:19	00:26:33	00:25:28	00:24:12	00:27:54	00:28:01	00:29:24	00:26:53	00:24:22	00:25:55	00:25:32	00:22:27	00:23:57	00:24:44	00:24:44
Demand (Responses)	909,392 (total)	74,902	74,495	75,885	74,241	73,441	78,003	77,385	81,447	80,495	69,746	75,519	64,780	67,354		
Hear & Treat %	13.4%	14.0%	13.8%	13.8%	13.5%	13.6%	13.2%	13.9%	12.8%	12.7%	12.7%	12.4%	12.1%	13.1%	15.4%	15.5%
Crew Clear	00:21:53	00:23:47	00:22:00	00:20:24	00:20:48	00:21:24	00:21:46	00:21:39	00:21:20	00:21:04	00:21:52	00:22:18	00:22:11	00:22:02	0019:00	00:19:03
Vehicle Availability: DCA	80.2%	78.0%	77.6%	79.4%	77.2%	79.0%	83.0%	81.7%	83.5%	81.8%	80.8%	81.3%	86.7%			
Sickness (A&E)	7.2%	6.9%	6.9%	6.9%	6.9%	6.3%	6.4%	7.1%	8.7%	8.5%	7.7%	7.7%	7.4%	7.1%	7.2%	7.2%
Arrive to Handover	00:19:14	00:20:59	00:19:50	00:19:18	00:17:47	00:17:44	00:18:00	00:18:21	00:19:03	00:20:25	00:18:25	00:17:22	00:17:28	00:17:54	00:19:04	00:19:23
Appraisal Compliance (A&E Ops)	79.2%	72.0%	71.5%	71.4%	72.9%	75.9%	78.7%	80.9%	82.1%	83.6%	86.5%	91.2%	90.6%			90.0%
IUC Not Ready Reason Codes – Health Advisor	28.0%	27.7%	30.9%	29.0%	26.6%	28.7%	27.1%	28.0%	26.0%	27.8%	29.0%	27.4%	28.2%	28.2%	28.2%	
IUC Clinical Call Backs in 1 hour	41.3%	46.7%	47.4%	47.7%	47.0%	47.2%	44.6%	36.3%	32.6%	33.7%	37.4%	37.4%	27.4%	26.6%	25.6%	
PTS KPI 1 deliver journey times less than 120 mins	97.1%	97.1%	96.9%	97.1%	97.2%	97.1%	97.3%	97.2%	97.1%	97.2%	97.2%	97.0%	96.8%	97.4%		91.3%
PTS KPI 3 deliver pre planned pick up within 90 mins	89.5%	88.3%	89.0%	88.9%	90.8%	89.6%	91.2%	89.5%	89.7%	89.4%	89.3%	89.7%	90.0%	90.4%		90.0%

Metric	BASELINE (25/26 YE ave)	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 26	Feb	Mar	Apr	May	YE Forecast	YE Operating Plan
PTS KPI 4 Deliver short notice pick up within 120 mins	80.1%	75.9%	76.3%	77.2%	81.5%	79.5%	81.9%	79.1%	80.7%	81.8%	84.6%	83.0%	82.3%	80.7%		88.3%
PTS patients per vehicle	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4		1.4
PTS Call Handling - answered in 180 seconds	88.0%	68.4%	80.2%	89.6%	84.6%	91.2%	87.0%	92.4%	91.5%	85.5%	87.2%	88.5%	71.1%	96.0%		

Note:

1. Red shaded cells indicate the count/rate is off track against the month's planned target and a green rating means the metric is on track with no significant issues.

Source: Trajectory Report, YAS BI Portal, data downloaded 09/06/26

TABLE 3: NHS OVERSIGHT FRAMEWORK METRICS TABLE

This table presents a set of key performance metrics used to assess the Trust's performance across several domains, as required by the NHS Oversight Framework. Each metric is reported with its value, unit, score, rank (out of 10), and the average value for comparison. Key insights:

- The Trust performs well in staff engagement and advocacy (ranked 1 out of 10).
- Response times they remain better than the average (rank 3/10).
- Sickness absence increased slightly in Q4 but remains a key focus for improvement.

Quarter	Segment	Trust in financial deficit?
Q4 2025/26	1 - High performing	No

- Financial metrics are stable, with no planned deficit and minimal variance to plan.

Domain	Sub-domain	Metric description	Release Frequency	Metric Value	Q3					
					Reporting Date	Metric Value	Average value	Metric value change	Metric score	Rank out of 10
Access to services	Urgent and emergency care	Average Category 2 ambulance response time	Monthly	mins	To Mar 2026	26.25	28.93	-0.33 ↑	1.00	3
Effectiveness and experience	Effective out of hospital care	Percentage of ambulance patients conveyed to emergency departments	Monthly	%	To Mar 2026	52.9	48.70	0.20 ↓	3.40	9
	Patient experience	NHS staff survey advocacy score	Annual	out of 10	2025	6.67	6.2	0.09 ↑	1.00	1
Finance and Productivity	Finance	Planned surplus/deficit	Annual plan	%	2025/26	0.00	0.00	0.00 →	1.00	2
		Variance year-to-date to financial plan	Year to date	%	Month 9 2025	0.54	0.14	0.14 ↓	1.00	6
		Combined finance	Year to date	score	Q3 2025/26				1.00	
	Productivity	Relative difference in costs	Annual	%	2024/25	96.71	96.16	0.00 →	1.99	6
Patient safety	Patient safety	NHS Staff survey – raising concerns sub-score	Annual	out of 10	2025	6.27	5.94	0.14 ↑	1.00	1
People and workforce	Retention and culture	Sickness absence rate	available monthly - Quarterly aggregated monthly figures	%	Q3 2025/26	8.03	7.74	0.99 ↓	3.91	7
		NHS staff survey engagement theme	Annual	out of 10	2025	6.29	5.91	0.06 ↑	1	1

Source: NHS England, 11/06/26

Board of Directors (in Public)
23 July 2026

Report Title	Quality Committee Chair's Report
Author	Becky Malby, Non-Executive Director and Chair of Quality Committee
Accountable Director	Becky Malby, Non-Executive Director and Chair of Quality Committee
Previous committees/groups	
Recommended action(s) (assurance, approval, information)	Information / Assurance
Purpose of the paper	The report provides highlights of the Quality Committee to provide assurance to the Trust Board.

Executive Summary

The report provides highlights from the work of the Quality Committee (QC) on 11 June 2026 to provide assurance to the Trust Board.

The paper aims to update the board on the work of the Committee to reduce the risks set out in the Board Assurance Framework where the Quality Committee is responsible for assurance.

Recommendation(s)	The Board are asked to note the contents of the report and the proposed Board actions.
Link to Board Assurance Framework Risks (board and level 2 committees only)	RISK 2 Access to Appropriate Care RISK 3 Quality for Patients RISK 4: Strengthen Medicines Management RISK 11 Collaborate effectively to improve population health and reduce health inequalities.

Highlight Report

Report from: Quality Committee

Date of the meeting: 11 June 2026

Key discussion points at the meetings and matters to be escalated to board:

Alert:

1. Performance on call answering.
   There were over 2,000 two-minute waits (circa 70 per day in May), as a result of staffing availability. The plans for the coming 12+ months on integrating 999 and 111, and the move to answer 999 calls at Callflex, means there is action in place for the medium term, but the next six months will be challenging, and we are performing at the bottom of the sector as a whole. While this increases the risk of harm, we have not seen any specific patient safety issues.

2. The committee received the Infection Control report and alerts the Board that there is moderate assurance that governance and oversight is effective. There is a plan to improve this with clear priorities for 2026-7.

Advise:

3. DNR
   A recurrent theme raised by staff is the variability in accessing DNAR and RSPECT forms through the YAS footprint. This is recognised by the End of life Ambulance Committee and discussion with NHS pathways is ongoing. Locally the three ICBs approach this differently utilising different platforms to hold this information.

4. Visits
   The Committee reviewed the visit reports and agreed that the summary report coming to Board and committees needed TEG oversight, and that the reports are useful to inform executives in terms of operational issues and the QI team in terms of learning.

Assure:

5. Mortality Oversight.
   After alerting the Board to this issue last month a new governance structure has now been established and was reviewed at Committee this month. This will also be the subject of an internal audit this year

6. Clinical Supervision - uptake and impact.
   There is a plan to embed this as part of the new process for staff appraisals to help ensure coverage across all staff.

7. The Committee approved the Quality Accounts, was assured on the evidence presented, and noted the valuable feedback from partners. The Committee asked Lesley Butterworth to take the Healthwatch comments to the Critical Friends Group and incorporate into the patient experience work.

8. The Committee undertook a ‘deep dive’ discussion on the quality and availability of our Mental Health response and was assured by the significant and trailblazing work undertaken by Louise Whittaker and the team. The Committee noted the MH dashboard which provides valuable data for discussion in meeting need with system partners but also feeds into our business planning for next year in terms of our response to MH need. The Committee noted the demand, that YAS had 133,000 calls for mental health needs in 2025-6, and 10% of our A&E stack relates to people with mental health needs.

9. The Committee noted the report on internal audit actions and was assured on the progress made to complete the audit requirements.

Risks discussed:
The BAF risks aligned to the Committee for oversight were discussed both in the specific agenda item but also in each of the agenda items with this report clearly linking to the BAF.

New risks identified:
No new risks were identified

Report completed by: Rebecca Malby
Reviewed by Melanie Hudson, Marc Thomas, Dave Green
Date: 11.06.2026

Board of Directors (in Public)
23 July 2026

Report Title	Quality Committee Chair's Report
Author	Becky Malby, Non-Executive Director and Chair of Quality Committee
Accountable Director	Becky Malby, Non-Executive Director and Chair of Quality Committee
Previous committees/groups	
Recommended action(s) (assurance, approval, information)	Information / Assurance
Purpose of the paper	The report provides highlights of the Quality Committee to provide assurance to the Trust Board.

Executive Summary

The report provides highlights from the work of the Quality Committee (QC) on the 9th July 2026 to provide assurance to the Trust Board.

The paper aims to update the board on the work of the Committee to reduce the risks set out in the Board Assurance Framework where the Quality Committee is responsible for assurance.

Recommendation(s)	The Board are asked to note the contents of the report and the proposed Board actions.
Link to Board Assurance Framework Risks (board and level 2 committees only)	RISK 2 Access to Appropriate Care RISK 3 Quality for Patients RISK 4: Strengthen Medicines Management RISK 11 Collaborate effectively to improve population health and reduce health inequalities.

Highlight Report

Report from: Quality Committee

Date of the meeting: 9 July 2026

Key discussion points at the meetings and matters to be escalated to board:

Alert:

1. A critical incident in terms of the lack of safety in relation to storage of Morphine on an ambulance, has resulted in a report to the home office, CQC and is now subject to formal management processes. No harm occurred but the lack of safety in this incident is of significant concern.

Advise:

2. Clinical Supervision is under reported across YAS and it is not clear that there is spread across all areas. This is being addressed in this year's workplan. In addition, the Team Leader role is going to be clearly articulated to strengthen clinical leadership.

3. The committee received the operational report and noted the improvement in hear and treat which is likely to be sustained, and the links between the operational work and the clinical model which has the potential to reduce conveyancing with the use of more skilled staff to support decision making at the point of contact.

4. Across the agenda in this committee, the issue of whether the workforce plan now reflects the developing model of professional practice emerged as a common theme (from the papers on clinical supervision, the clinical model and the discussion on learning). The professional model will be a major contributor to increasing staff's skills and quality of practice, staff morale and also the reduction in sickness. There is a question about whether the current workforce model reflects the time needed for professional practice development including educational sessions and accessing clinical supervision. The Chair will bring this to the attention of the Chair of the People Committee.

5. The committee noted the rise in demand resulting from the excessively hot weather and the impact this will have and has had on response times.

Assure:

6. The Committee received a report on 111 and EOC, which demonstrated and provided assurance that:

   a) The learning from the incident reviews/Datix is being embedded into business as usual;
   b) There is demonstrable progress on ensuring YAS is doing all it can to be efficient and effective in its own internal workings, and that gives YAS the opportunity to be clear on our ask from system partners in terms of alternative pathways.

7. The Committee received a verbal update on the progress with translation services and was assured that this will help mitigate risk on health inequalities. 8. The committee received the patient experience quarterly report and was pleased to note the public's interest in joining critical friends and the success in recruiting from a diverse range of people that helps our critical friend network reflect the people we serve. The committee was assured that the complaints process is continuing to improve and times for resolution continue to fall and noted that YAS has reached out to Healthwatch as a result of the feedback in the quarterly report to improve the intelligence on the public's concerns. Finally, the committee heard that progress is being made to ensure our payment processes for public participation are in line with national policy.
Risks discussed: The BAF risks aligned to the Committee for oversight were discussed both in the specific agenda item but also in each of the agenda items with this report clearly linking to the BAF.
New risks identified: No new risks were identified

Report completed by: Rebecca Malby
Reviewed by: Dave Green
Date: 9 July 2026

Board of Directors (in Public)
23 July 2026

Report Title	Quality & Clinical Highlight Report
Author	Dave Green, Executive Director of Quality & Chief Paramedic Shona McCallum, Executive Medical Director
Accountable Director	Dave Green, Executive Director of Quality & Chief Paramedic Shona McCallum, Executive Medical Director
Previous committees/groups	Individual subjects discussed at: TEG, Quality Committee, Clinical Governance Group (CGG), Patient Safety Learning Group (PSLG) and Clinical Quality Development Forum (CQDF)
Recommended action(s) (assurance, approval, information)	For Information and Assurance
Purpose of the paper	To update on highlights, lowlights, issues, actions and next steps in relation to Quality and Clinical areas.

Executive Summary

Highlights

- The Clinical Directorate and Quality and Professional Standards Directorate have concluded their consultation on the proposal to join to form a single cohesive directorate, the Clinical Quality Directorate. Following consultation, the proposal has been confirmed and will formally commence implementation from 3 August 2026.

- The report highlights positive progress across the Quality and Clinical portfolios, including improved complaints performance, strengthened patient safety capacity, and continued development of patient experience and quality governance arrangements. Good progress is also noted in clinical effectiveness, research activity, quality improvement, and the implementation of tools and programmes that support learning, assurance and service improvement.

Lowlights

- Key areas requiring continued focus include capacity pressures, inconsistent application of proportionate learning responses, limitations in Datix action tracking, and risks around Accessible Information Standard compliance. Clinical audit findings also identify variation in pain management and falls care bundle compliance, with further improvement work underway to strengthen assurance and support consistent practice.

Recommendation(s)	Provide oversight on the clinical effectiveness and quality of care delivered, including the areas of improvement identified.
Link to Board Assurance Framework Risks (board and level 2 committees only)	1. Deliver a timely response to patients. 11. Collaborate effectively to improve population health and reduce health inequalities.

QUALITY AND CLINICAL UPDATE 23 July 2026

Highlights	Lowlights
Patient Safety • The Trust welcomed a new Patient Safety Team Manager in June. This post provides much welcomed capacity to the team, as well as bringing a wealth of external experience in PSIRF (Patient Safety Incident Response Framework) arrangements from the wider health sector. • Thematic reviews are being used to explore complex patient safety topics and translate findings into practical organisational learning. The Trust has completed a second Medication Thematic Safety Review which has highlighted several areas of learning. This supports a more reflective approach, moving the focus from identifying "what went wrong" to understanding "what can we learn" and how this can improve future practice. **Patient Experience** • Complaint response times have continued to improve, with the 2025/26 improvement target achieved and a final year-end position showing a 23% reduction in complaint response times. Early 2026/27 performance is also positive, with a year-to-date average response time of 74.32 days, representing a 29% improvement. • The overall complaints caseload has reduced to 149 cases, with each coordinator currently holding around 25 cases, creating a more stable platform for sustaining improved response times. • All Patient Experience Internal Audit actions have been completed and signed off ahead of the May deadlines, providing assurance that agreed improvements relating to learning from complaints and incidents have been progressed. • The Quality Governance Assurance Forum (QGAF) has commenced, strengthening oversight of learning and actions from complaints, incidents and wider patient experience feedback, and supporting improved triangulation across quality intelligence. • The 2026/27 patient experience quality priority has started through the SMS survey pilot, with early indications suggesting positive engagement and most responses received within 24 hours of texts being sent. • Patient Safety Partners are transitioning into Patient Experience, aligning PSP activity with complaints, concerns, compliments, surveys, engagement and other patient voice routes while maintaining links with Patient Safety and Patient Safety Specialists. This should strengthen the use of lived experience insight in safety learning and improvement. • Further patient experience deep dives are planned, including work with COPD patients linked to the King's Fund neighbourhood project, maternity care, patients cared for by volunteers, and real-time PTS feedback with a focus on those at risk of digital exclusion. **Clinical Effectiveness and Research** • **JRCALC+ Emergency Mode** YAS is one of three ambulance trusts participating in the evaluation of JRCALC+ Emergency Mode, a filtered version of the JRCALC+ app designed to help clinicians access key guidance more quickly for critically unwell patients. At the time of reporting, YAS is leading the evaluation in both usage and volume of feedback received. Early staff engagement via OneYAS has been consistently positive, indicating that Emergency Mode is supporting staff access to guidance in high-acuity situations. • **Ligature Audit and Suicide Prevention** A Bradford-based audit presented at CQDF received widespread positive praise, identifying increased use of ligatures, particularly among younger patients, and highlighted opportunities to strengthen patient safety, staff support and suicide prevention. The findings will inform	**Patient Safety** • Proportionate learning responses remain inconsistently applied. A learning response and PSIRF 'lite' training package will be introduced throughout the remainder of the financial year, supported by closer working with the QI team. The additional team manager role will support increase leadership capacity and influence. **Patient Experience** • Capacity pressures remain within the Patient Experience Advisor team due to sickness absence and vacancy, resulting in continued reliance on alternative duties staff, although the position is improving. • Datix limitations are affecting the ability to consistently identify, log and monitor patient experience feedback actions, creating a risk to demonstrating action tracking and evidence of learning. This is impacting the effectiveness of QGAF. Issues have been raised urgently with Datix • Accessible Information Standard compliance remains a local risk, particularly around the consistent identification, recording and application of reasonable adjustments across patient-facing and corporate services. • The SMS survey pilot is promising but not yet fully embedded, with further work needed to enable batch text sending, support monthly distribution and reduce reliance on postal surveys. • The transition of Patient Safety Partners into Patient Experience requires careful implementation, including clear scope, maintained links with Patient Safety and PSS colleagues, and impact reporting to ensure the move strengthens patient safety involvement. **Clinical Effectiveness and research** • **Pain Management Audit** Review of 2,943 patient records identified variation in pain assessment, analgesia use and reassessment. These findings reflect recognised challenges in delivering consistent pain assessment and management across pre-hospital and urgent and emergency care. A multidisciplinary task-and-finish group has been established to oversee improvement actions across clinical practice, education, digital systems and patient experience. • **Falls audit** Identified low compliance with the national falls Ambulance Clinical Outcome (AmbCO) care bundle. Findings have been shared with the Urgent Care Steering Group and will also inform consultant-led improvement activity against the falls AmbCO bundle. Compliance and improvement will be monitored through the available AmbCO dashboard, to provide ongoing oversight, however dashboard data is subject to a reporting lag - a working group has been established to review this. This will support future assurance through evidence of improved compliance in subsequent audit cycles. • The CRASH-4 interventional drug study is due to close by the end of this year, but we do not have another large-scale interventional trial in the pipeline, risking sustainability of paramedic trial recruitment models.

shared intelligence with system partners, exploration of specialist ligature-cutting equipment, and further prevention-focused improvement work.

- **Clinical Supervision in the Appraisal Proposal**
  Clinical Quality Development Forum (CQDF) supported proposals to incorporate clinical supervision and CPD discussions into annual career conversations. This provides an opportunity to identify learning needs earlier, improve access to targeted support, strengthen clinical decision-making confidence and provide greater assurance that staff are maintaining competence in high-risk and complex areas of practice.

- **NQP Development Days**
  Approximately 350 places were provided during the March–April 2026 Newly Qualified Paramedic development days, with near-full attendance. Feedback was highly positive, with an average score of 8.8/10; 86.9% of attendees reported feeling better prepared for practice and 98.4% reported improved knowledge. This provides assurance that the programme is supporting clinical confidence, capability and professional development.

- The YAS-hosted, and -sponsored PERIFERAL study (incidental findings), has received all of its approvals and begun to recruit participants, on track with study milestones. Similarly, the Longlies and TEMPEST (temperature monitoring of medicines in vehicles) NIHR-funded and YAS-hosted studies are on track. The YAS Research Institute (YASRI)has been awarded £100,295 in Research Capacity Funding in recognition of research leadership for 2026-27. YASRI have brought together two stakeholders (York St John University and the Yorkshire and Humber Applied Research Collaborative) to match fund a PhD opportunity around urgent and emergency care campaigns which has advertised the stipend position.

- In early July, the Clinical Effectiveness and Audit Team welcomed Martin Havenhand (YAS Chair), who met with team members to gain insight into the department's work.

- The AmbCO Dashboard is now available on the Power BI app, produced and completed by the Clinical Effectiveness and Audit Team in collaboration with the Business Intelligence team. This has been launched with clinical leads for roll out in their areas. This ensure that all national clinical outcome data is available for operation teams to review and implement recommendation, learning and drive local improvement. This data is provided 3 to 4 months after collection, clinical auditing and quality checking by the clinical effectiveness and audit team.

Compliance, quality assurance and quality improvement

- **Health and Safety Policy**
  The Trust Health and Safety policy was reviewed and approved at TEG on 17 June. The policy has undergone thorough review bringing it up to date with structural changes across the organisation. No relevant changes to legislation were noted, with no significant policy changes required. The Safety Team are currently undergoing structural changes which will further benefit safety for the Trust.

- **Trust Risk Assessment Management**
  A recent internal audit provided recommendations for the strengthening of the risk management processes. Work is progressing on implementing a digitalised system utilising the Trust Microsoft 365 infrastructure. This is expected to widen access to risk assessment, improve central coordination, and assist timely review.

• **Quality Improvement Fellowship** In June, applications were opened for the next cohort of Quality Improvement Fellows, a first of its kind programme in the ambulance sector. The fellowship model has evolved over several years to meet the needs of staff; this year has seen significant expressions of interest across the organisation with requests for additional places by some service lines. • **Quality Improvement Team** The Quality Improvement team completed a restructure earlier in 2026. Following recruitment processes the team is expected to be in full establishment from July 2026. The team continue to positive progress the QI Enabling Plan and are making good headway in delivering improvement-orientated approaches for the Trust Business Priorities with a number of Plan, Do, Study, Act (PDSA) cycles being undertaken across Operations and Remote Patient Care to test changes, generate learning and support sustainable improvement. • **Quality Account Publication** Following Trust Board approval, the Trusts annual Quality Account 2025-26 was published on the Trust website and communicated to stakeholders.		

Key Issues to Address	Action Implemented	Further Actions to be Made
• Staffing and capacity •	• Safety Team restructure proposal is currently underway	• Continue to focus on AmbCO audits and actions

NHS
Yorkshire
Ambulance Service
NHS Trust

Management of Deceased Patients Policy

Document Author: Deputy Medical Director

Date Approved: May 2024

Document Reference	PO – Management of Deceased Patients – May 2027
Version	V: 3.0
Responsible Director (title)	Executive Medical Director
Document Author (title)	Deputy Medical Director
Approved by	Clinical Governance Group
Date Approved	May 2024
Review Date	May 2027
Equality Impact Assessed (EIA)	Yes
Document Publication	Internal and Public Website

Document Control Information

Version	Date	Author	Status (A/D)	Description of Change
0.1	10/02/2017	Dr Steven Dykes	D	Initial draft document
0.2	13/11/2017	Dr Steven Dykes	D	Document updated following EIA, and feedback from CGG, and South Yorkshire Police
1.0	07/02/2018	Dr Steven Dykes	A	Approved at TMG
1.1		Dr Steven Dykes	D	Updated with new definitions of conditions unequivocally associated with death in children younger than 18 years
2.0	28/05/2020	Steven Dykes	D	Updated following consultation with North Yorkshire and West Yorkshire Police and Coroners Offices
2.0	Nov 2020	Ruth Parker	A	Approved by TMG
2.1	June 2023	Risk Team	A	TMG approved extension until November 2023
2.2	December 2023	Steven Dykes	D	Circulated draft for internal and external consultation
2.3	May 2024	Risk Team	D	Policy formatted to Trust new visual identity.
3.0	May 2024	Risk Team	A	Policy approved within May 2024 Clinical Governance Group.
A = Approved D = Draft				
Document Author – Dr Steven Dykes Deputy Medical Director				
Associated Documentation: Resuscitation Policy Safeguarding Policy (Children, Young People and Adults at Risk) Mortuary Pathway Procedure West Yorkshire Police and YAS Attendance at Death Procedure North Yorkshire Police and YAS Attendance at Death Procedure				

Staff Summary

The nature of the death, where the death has occurred, and the context in which it has occurred effects what needs to happen and who needs to be informed.
Once verification has confirmed the patient as deceased, clinicians must provide care for the deceased's relatives and depending on the circumstances inform the deceased patient's own medical practitioner/GP and/or the police if required.
Only in exceptional circumstances will YAS transport deceased patients.
All unexpected deaths must be referred to police – In some areas a police officer will always attend and in some areas a remote decision will be made on attendance or not – please refer to local procedures.
The police provide the most appropriate route for ambulance clinicians to refer cases to the coroner; however, the patient's own GP will refer the case to the coroner if they are unable to complete a medical certificate of the cause of death.
From September 2024 there is a statutory requirement that all deaths that are not referred directly to a coroner are independently scrutinised by a Medical Examiner. This referral will be made by the doctor or by the mortuary/funeral home.
All deceased children (child is defined as a person under 18 years old) meeting the criteria for a Joint Agency Response should be transferred to the nearest appropriate Emergency Department to enable the JAR to be triggered. The default position for any child death should always be to attend the Emergency Department, but with older children where the cause of death is more apparent (for example, stabbing), a decision may be made to transfer straight to mortuary facilities or to remain in situ at the crime scene to allow other forensic processes to take place under the guidance of the Force Incident Manager (FIM)

1.0 Introduction

1.1 Caring for a person at the end of their life, and after death, is enormously important and a privilege. There is only one chance to get it right.

2.0 Purpose/Scope

2.1 This policy is applicable to all YAS staff who have a responsibility for providing care to deceased patients.

2.2 Care after death includes:

- Honouring the spiritual or cultural wishes of the deceased person and their family/carers whilst ensuring legal obligations are met.
- Ensuring that the privacy and dignity of the deceased person is maintained.
- Ensuring the health and safety of everyone who encounters the body is protected.

3.0 Background

3.1 The nature of the death, where the death has occurred, and the context in which it has occurred effects what needs to happen and who needs to be informed.

3.2 For example, some deaths are expected or peaceful while others may be sudden or traumatic. As a result, families and carers are likely to have a range of responses and needs and each may also have differing views about how the person should be cared for after death. YAS clinicians should respect the wishes of the patient and relatives following death unless there is a legal requirement to do otherwise.

3.3 Once verification has confirmed the patient as deceased, clinicians must provide care for the deceased's relatives and depending on the circumstances inform the deceased patient's own medical practitioner/GP and/or the police if required. Only in exceptional circumstances will YAS transport deceased patients.

3.4 Not all deaths have to be reported to the coroner. In most cases the deceased's own doctor who was treating them will be able to supply a medical certificate of the cause of death. But some deaths must be reported to the coroner. The coroner is an independent judicial officer appointed to investigate all sudden, violent and unexplained deaths of persons who have either died in, or whose bodies are brought into, the area. In certain cases, the coroner must hold an inquest to determine who, when where and how the deceased came by their death. Referral to the coroner is required.

- When no doctor has treated the deceased during his or her last illness, or
- When the doctor attending the patient did not see him or her within 28 days before death, or after death, or
- When the death occurred during an operation or before recovery from the effect of an anaesthetic or
- When the death was sudden and/or unexplained or attended by suspicious circumstances, or
- When the death might be due to an industrial injury or disease, or to accident, violence, neglect or abortion, or to any kind of poisoning, or
- When the death occurred in prison or in police custody

3.5 The Police provide the most appropriate route for ambulance clinicians to refer cases to the coroner; however, the patient's own GP can refer the case to the coroner if they are unable to complete a medical certificate of the cause of death.

3.6 The Police must always be contacted:

- Where the circumstances of the death cannot be explained
- If the deceased is under 18 years of age
- If the identity of the deceased cannot be confirmed
- Where death did not occur in the home of the deceased or relative of the deceased *(home includes residential home and gardens / yards etc.)*
- If there is no known General Practitioner (GP) for the deceased
- Where a relative/other responsible person is not easily contactable
- If there are obvious physical signs of trauma or apparent deliberate violence
- Where there are signs of forced entry
- Deaths caused as a result of industrial or agricultural accidents and work-related. deaths
- Suspected Suicides
- Suspected Drug related deaths
- Deaths as a result of drowning including diving deaths.
- Deaths in police or prison custody whilst serving a custodial sentence or if
- lawfully detained in any institution
- Deaths on the railway (responsibility of British Transport Police)

- Deaths at MOD Establishments
- Deaths as a result of fires
- Fatal road traffic collisions

3.7 From September 2024 there is a statutory requirement that all deaths that are not referred directly to a coroner are independently scrutinised by a Medical Examiner. This referral will be made by the doctor or by the mortuary/funeral home. Medical Examiners are senior doctors who are based at hospitals and their role is to agree the proposed cause of death and accuracy of the medical certificate with the doctor completing it, discuss the cause of death with relatives and establish if you have any questions or concerns with care before death and act as a medical advice resource for the local coroner. The Medical Examiner may refer the death to the coroner if there are any concerns about care before death.

3.8 **Recognition of Life Extinct (ROLE)**

3.8.1 Verification of death and termination of resuscitation is detailed in the JRCALC clinical guidelines.

3.9 **Expected death or death is not unexpected.**

3.9.1 This occurs where a death was anticipated, expected, and predicted and there are no unusual circumstances, and the person has been assessed by a doctor or healthcare professional either remotely or in person during their last illness and within the last 28 days of life. In most cases, the patient's GP will certify the death and issue a Medical Certificate of Cause of Death (MCCD).

3.9.2 If the death occurs in the patient's own home, YAS will not usually attend, and the patient's own GP or out of hours doctor or practitioner would be asked to attend. However, if YAS clinicians are on scene, the deceased's own GP should be notified directly in-hours or via ePR Post Event Messaging out of hours. If the death occurred in a care home, or if the family or responsible adult are present, they can arrange a funeral director to attend and there is no requirement for the ambulance clinician to remain on scene.

3.9.3 It is the responsibility of the doctor with whom the deceased was registered to deal with the death certification procedure. The out-of-hours primary care service will be unable to complete the death certificate.

3.10 **Unexpected ("sudden") deaths**

3.10.1 The management of unexpected deaths will differ depending on which coronial area the patient has died in. Deceased patients must not be transported outside the coronial area in which they died.

3.9.2 All unexpected deaths must be referred to police – In some areas a police officer will always attend and in some areas a remote decision will be made on attendance or not – please refer to local procedures.

3.9.2 YAS would not normally transport the deceased patient and should only be considered in exceptional circumstances. YAS will not respond to body recovery requests from the police. Transport arrangements will depend on prior agreement with the coroner but may involve removal of the deceased to an agreed funeral director or mortuary.

3.10 Death in unusual or suspicious circumstances

3.10.1 When unusual or suspicious circumstances are present all reasonable precautions to preserve the potential crime scene should be taken and the Police called to attend.

3.10.2 In cases where an adult dies and abuse or neglect, whether known or suspected could be a contributory factor and there is concern that partner agencies could have worked more effectively to protect the adult, the YAS safeguarding team should be informed via the generic secure email address yas.safeguard@nhs.net The safeguarding team should inform the local safeguarding adults board in line with S.44 of the Care Act 2014 so that consideration can be given to whether the case meets the threshold for a Safeguarding Adults Review (SAR).

4.0 Process

4.1 Patient Transport Service – See PTS SOP

4.2 NHS 111 – see the Expected/Unexpected SOP

4.3 999/Emergency Operations Centre

4.3.1 All calls will be processed using The International Academy Medical Priority Dispatch System (AMPDS) or NHS Pathways. Resuscitation will be commenced unless the caller informs the call taker that the patient is beyond any help or the caller is certain that we should not try to resuscitate the patient.

4.3.2 Obvious death will only be unquestionable in the following situations;

- Cold and stiff in a warm environment
- Decapitation
- Decomposition
- Incineration

4.3.3 Expected death determinant will be used when a valid Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order is offered. If a DNACPR is in place, but the caller believes the DNAR should be ignored or is uncertain the DNACPR is valid, an appropriate response and resuscitation attempt will be made. DNACPR is not valid when the patient experiences a cardiac arrest due to a reversible condition such as choking, overdose or trauma.

4.4 Death in the ambulance

4.4.1 When a patient with a DNACPR dies during transport in an ambulance the patient can be taken to an appropriate destination. If there is any doubt on if the death is expected or not, the procedure for unexpected deaths must be followed and the patient must not be transported outside the coronial area in which they died. Non-Emergency Patient Transport Service staff must follow agreed local procedure before moving the patient. The preferred location may be documented in any end-of-life care plan, or patients stated preference, if not the following guidance may be used:

Transport between hospital and home	Take to hospital mortuary
Transport between hospice and home	Return to hospice
Transport between hospital and hospice	Take to hospital mortuary

Transport between hospice and hospital	Return to hospice
Transport between home and hospital	Take to mortuary
Transport between home and hospice	Continue to hospice
Transport to nursing home from home address	Take to nursing home

4.4.2 The receiving location must be contacted to notify them of the death and to accept the body. It is the responsibility of YAS staff to inform the sending and receiving location of the patient death and inform the patient's own GP of the death and destination of the body.

4.5 **Children**

4.5.1 The national JRCALC guidelines detail the management of a child death. Resuscitation should always be attempted unless there is a condition unequivocally associated with death or a valid advance decision/Limitation of Treatment Agreements (LOTA)/ReSPECT confirming that the clinician should not attempt resuscitation. In most circumstances if the clinician has confirmed death, it will still be appropriate to transfer the child and family to an Emergency Department with paediatric facilities where the Joint Agency Response (JAR) may be initiated. An exception might be an expected death of a child and where the LOTA gives advice to remain at home or transport to a hospice or other facility.

4.5.2 If the death is sudden and unexpected with no immediate apparent cause, where the initial circumstances raise suspicions that the death may not be natural, could be due to external causes, occurs in custody or whilst detained under the Mental Health Act – or a stillbirth with no healthcare professional in attendance then a JAR will be initiated.

4.5.3 All deceased children (child is defined as a person under 18 years old) meeting the criteria for a JAR should be transferred to the nearest appropriate Emergency Department to enable the JAR to be triggered. The default position for any child death should always be to attend the Emergency Department, but with older children where the cause of death is more apparent (for example, stabbing), a decision may be made to transfer straight to mortuary facilities or to remain in situ at the crime scene to allow other forensic processes to take place under the guidance of the Force Incident Manager (FIM).

4.5.4 All child deaths should be escalated to the YAS safeguarding team along with the social care referral details via the generic secure email address yas.safeguard@nhs.net to enable prompt analysis and participation in statutory review processes.

4.6 **Management of indwelling devices after death**

4.6.1 If possible, remove any devices (e.g. LMA, ETT) for dignity purposes, however in cases of unexpected death once verification of death has been undertaken, all invasive devices (endotracheal tube, intravenous cannulae etc.) must be left in situ. Any monitoring/ defibrillator electrodes must also be left in place. Do not wash the body or begin mouth care in case it destroys evidence.

4.7 **Booking into the mortuary – See the Mortuary Pathway Procedure**

4.7.1 It is the responsibility of the admitting ambulance clinician to have sought a positive identification of the deceased. If identification is not possible or identification is not

certain, the police must be contacted. On arrival at the mortuary the YAS clinician must ensure the patient is tagged, and the local procedure followed.

5.0 Implementation Plan

5.1 The latest approved version of this Policy will be posted on the Trust Intranet site for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during Trust Induction.

6.0 Monitoring compliance with this Policy

6.1 Incidents and complaints logged on the Datix system will be reviewed for issues relating to management of the deceased.

7.0 Appendices

Appendix A - Definitions

- Expected Death

  Those whereby the GP/Consultant/Medical Officer concerned has diagnosed the patient as suffering from an advanced, progressive, incurable disease and has died due to the consequences of the disease.

- Unexpected Death (definitions below only to be used in North and West Yorkshire)

  Natural causes – a death that appears to have resulted from the normal progression of a naturally occurring disease, for example: heart disease; cancer; old age

  Unnatural causes - the death may be as a result of the actions of the deceased or of a 3rd party, for example: murder / manslaughter; drugs death; suicide; trauma; injury.

- Responsible Person

  Definition of Responsible or Competent Person

  - One who is able to understand the information relevant to the decision.
  - One who is able to retain that information.
  - One who is able to use or weigh that information as part of the process of making the decision.
  - One who is able to communicate their decision by using any recognisable means of communication.
  - The factors that will determine that the individual is capable of looking after the patient are:
    - Has access to a telephone.
    - Knows the patients General Practitioners contact details.
    - Is able to communicate with the emergency services.

Appendix B - Roles & Responsibilities

All Patient Facing Staff
All patient facing staff must work to their scope of practice when undertaking decisions on withholding or terminating resuscitation and verification of death. All decisions must be compliant with JRCALC Ambulance Clinical Practice Guidelines. All staff must fully document all rationale and decisions taken on the patient report form. All patient facing staff have a responsibility to follow this policy

Clinical Business Unit Leadership Teams
Consultant Practitioners are responsible for joint working with local police forces, coroners and NHS system partners on local procedures and pathways regarding deceased patients. Any changes to the management of deceased patient procedures and pathways must be approved at the Trusts Clinical Governance Group

Deputy Medical Director
The Deputy Medical Director is responsible for ensuring this policy is compliant with national policy and legislation and kept up to date.

Clinical Governance Group
Clinical Governance Group is the responsible group for approving this policy and any associated procedures and pathways.

Board of Directors (in Public)
23 July 2026

Report Title	Conveyance and Management of Deceased Patients
Author	Dr Shona McCallum, Executive Medical Director
Accountable Director	Dr Shona McCallum, Executive Medical Director
Previous committees/groups	N/A
Recommended action(s) (assurance, approval, information)	For Approval
Purpose of the paper	To provide the Trust Board with an update on the guidance against Recommendations 30-33 from the Fuller Inquiry relating to the conveyance, security, dignity and management of deceased patients.

Executive Summary

Yorkshire Ambulance Service NHS Trust has reviewed its current position against Recommendations 30–33 of the Fuller Inquiry and the NHS England requirements arising from the Nottingham maternity review findings on post-death care. The review confirms that governance arrangements and a Management of the Deceased Policy are already in place; however, further strengthening is required to ensure the Trust can provide clear Board-level assurance that deceased patients are conveyed, secured and managed with dignity, respect, security and appropriate oversight.

The key actions identified relate to improving data collection on the conveyance of deceased patients, making crew positioning explicit when a deceased patient is conveyed, strengthening guidance on covering and securing the deceased, clarifying arrangements for foetuses under 28 weeks' gestation, and setting out clear requirements for the use of photography. These amendments will be incorporated into the review of the Management of the Deceased Policy and presented to the Clinical Governance Group in September 2026, following which the revised guidance will be communicated across the organisation to support staff awareness, consistent practice and compliance.

The supporting clinical safety review of the ePR photo capture functionality provides additional assurance that the use of clinical imagery has been assessed and governed appropriately. The review identified risks relating to inappropriate image capture, consent, image storage and synchronisation, viewing of sensitive images, and potential delay to patient care. Mitigations include on-screen consent and information governance guidance, mandatory image classification and contextual notes, the ability to delete images prior to finalisation, audit logging, secure storage within the ePR rather than on the device, controlled viewing arrangements for receiving clinicians, and explicit prompts that photo capture must not delay care.

Following application of these controls, all identified residual risks associated with photo capture have been reduced to low and assessed as As Low As Reasonably Practicable. The clinical safety review concludes that the module is safe for deployment in its intended setting, while recommending continued monitoring during rollout, maintenance of the hazard log, incorporation of findings into the Clinical Safety Case Report, and consideration of a dedicated clinical photography policy or scope of practice to support long-term consistency and governance.

There are no financial implications identified. The principal risk is that failure to comply with national recommendations and strengthened local guidance could compromise the dignity, security and respectful management of deceased patients. The Board is therefore asked to note the assurance provided, support the planned policy updates and approve the assurance statement.	
Recommendation(s)	The Trust Board are asked to note the updated guidance to strengthen the policy to provide clearer guidance for staff and approve the assurance statement.
Link to Board Assurance Framework Risks (board and level 2 committees only)	1. Deliver a timely response to patients. 2. Provide access to appropriate care. 3. Deliver quality for patients.

Conveyance and Management of Deceased Patients

1.0 INTRODUCTION

1.1 This paper has been prepared in response to the NHS England letter dated 26 June 2026, issued to NHS Trusts and Integrated Care Boards following the Nottingham maternity review findings on post-death care and key actions required following the Fuller enquiry (link to report in Appendix 1). The letter asks NHS provider trusts to review their local arrangements for care, security, dignity and oversight of deceased patients, and to provide Board-level assurance that appropriate governance policies and action plans are in place.

2.0 BACKGROUND

2.1 YAS has undertaken a review of Recommendations 30–33 from the Fuller Inquiry relating to the conveyance and management of deceased patients. Whilst existing governance arrangements and policies are in place, further work has been identified to strengthen compliance and align with national recommendations. Actions are currently underway through policy review, governance oversight and service improvement initiatives. The current position and planned actions for each recommendation are detailed below.

3.0 PROPOSAL

3.1 **Recommendation 30**
Data on how often deceased patients are conveyed in ambulances, and the reasons for this, should be routinely collected and reported to NHS England and monitored to assess risk.

3.1.1 **YAS Response/Actions:**
YAS can provide data on cases where the clinical outcome was death, including conveyance location, patient age, gender and area. However, the reason for conveyance may not always be known. Clinical Effectiveness and Business Intelligence are working together to provide this data using ePR.

3.2 **Recommendation 31**
Every NHS ambulance service should have a policy setting out where ambulance crew members should sit when conveying deceased patients. This should include reference to the risk of abuse of deceased patients, as well as training requirements.

3.2.1 **YAS Response/Actions:**
YAS currently has a Management of the Deceased Policy in place. The policy is being reviewed and updated to ensure compliance with the recommendations arising from both the Fuller Inquiry and the Ockenden Review. Current practice in YAS is that crews are situated together at the front of the vehicle when conveying a deceased patient. This is not explicit in the current policy. The revised policy will include this guidance and further

staff responsibilities, awareness of potential abuse risks, and associated training requirements. The updated policy is scheduled for review and approval through the Clinical Governance Group (CGG) in September 2026.

3.3 **Recommendation 32:**
NHS ambulance services should have policies regarding the security and dignity of the deceased, including when the deceased should be covered and/or secured.

3.3.1 **YAS Response/Actions:**
The review of the Management of the Deceased Policy will strengthen guidance relating to the security, dignity and respectful care of deceased patients whilst in YAS care. Updates will include clearer expectations regarding the handling, covering and securing of deceased patients. Current practice in YAS is that snuggle pouches are used to convey deceased foetus under the age of 28-week gestation. This is not explicit in the current policy. The policy will be reviewed this guidance incorporated and brought to CGG in September 2026.

3.4 **Recommendation 33:**
Every NHS ambulance service must put policies in place regarding taking photographs of deceased patients, including any circumstances in which this may be required and ensure that staff are aware of and comply with them.

3.4.1 **YAS Response/Actions:**
As part of the wider review of the Management of the Deceased Policy, YAS will update and strengthen guidance relating to photography of deceased patients. This will include clarification of circumstances where photography may be necessary, governance requirements, and staff responsibilities. The updated policy will be presented to the Clinical Governance Group (CGG) in September 2026. Following approval, updates will be communicated across the organisation to ensure staff awareness and promote compliance. This work will support the wider objective of maintaining the dignity, security and respectful management of deceased patients at all times. There is a stand along policy on the management of patient photographs in Appendix 2 of this report.

4.0 FINANCIAL IMPLICATIONS

There are no financial implications.

5.0 RISKS

Failure to comply would result in a lack of security and dignity in conveying deceased patients.

6.0 RECOMMENDATIONS

6.1 The Board are asked to note the contents of the paper for assurance purposes and approve the assurance statement.

7.0 SUPPORTING INFORMATION

7.1 Attached Appendices:
Appendix 1: NHSE England Letter - Nottingham maternity review findings on post-death care and key actions required.
Appendix 2: Clinical Safety Review Photo Capture
Appendix 3: Board Assurance Statement
Appendix 4: Management of Deceased Patients Policy – separate attached document.

APPENDIX 1: NHSE England Letter - Nottingham maternity review findings on post-death care and key actions required

Classification: Official

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors
- clinical directors
- estates and facilities leads

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors
- estates and facilities leads
- communications leads

NHS England

Wellington House

133-155 Waterloo Road

London

SE1 8UG

26 June 2026

Dear colleagues,

Nottingham maternity review findings on post-death care and key actions required following the Fuller inquiry

Publication reference: PRN02500

The NHS holds a special responsibility for the care of patients from birth, throughout their lives and in death. At every stage, we must deliver care with dignity, respect and compassion.

When dignity after death is not preserved, the NHS betrays the trust that is placed in it and not only fails those that have died, but also their loved ones, adding to their grief and harm. As leaders, we must ensure this never happens by putting in place the right support and oversight, so that all staff working in the NHS consistently uphold dignity and care.

The further instances of unacceptable care of the deceased, amongst the many distressing findings of Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (NUH), are shocking. We must remember that this is not the first time that unacceptable care and poor oversight of mortuaries have been uncovered, and there is already a clear set of actions to strengthen and improve this area of care. The findings of Donna Ockenden's report should be considered alongside the Phase 2 report of the independent inquiry into the heinous crimes of David Fuller, published in July 2025. The report made 75 recommendations to strengthen the protection, security and dignity of people after death, including 29 that are immediately relevant to the NHS.

In response to Donna Ockenden's review and the Human Tissue Authority's (HTA) recent report on NUH, the Government has announced that the HTA is taking immediate action with a new requirement for mortuaries to review HTA reportable incident (HTARI) internal records from 2015-2026. This audit will ensure that all reportable incidents during this period have been logged with the HTA, and that any missing incidents are reported retrospectively. A Regulatory update will be issued by the HTA in July setting out the parameters, timeframe, process and deadlines for the evidential compliance audit. The HTA will report findings to the Secretary of State in October.

We know that the NHS has been working hard to meet the recommendations following the independent inquiry into the actions of David Fuller. However, in light of these further terrible findings, we are asking you not only to ensure compliance, but that you are rigorously reviewing your mortuary departments on a regular basis. To do this, ask yourselves the question 'what do you really know about the culture of your services, and the values and behaviours of your staff?'.

No system or process can totally mitigate malign or malicious intent. However, every Board member and senior leader involved in the care of the deceased should read these reports and ask themselves if this could be happening in their organisation. They should explore this by visiting services, listening to staff, encouraging concerns to be raised and acted on, and asking themselves whether the care provided would be good enough for their own loved ones. Boards are responsible for maintaining clear oversight of mortuaries, related storage areas and any other areas where people who have died are cared for, and for ensuring dignity, security and post-death care are central to local planning, governance and delivery.

To support this oversight, **Annex 1** summarises the guidance and support NHS boards should consider, and **Annex 2** maps the NHS-focused Fuller Inquiry recommendations to this guidance.

Trusts are asked to cascade this letter to relevant teams, including estates, safeguarding, pathology, bereavement, mortuary, corporate services, and your Freedom to Speak Up Guardians. Issues requiring support or escalation should be raised through regional teams.

Every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

On the basis that all NHS providers may be involved in caring for people after they die, we need assurance that each Board has robustly tested its position. **All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, are asked to complete and return the Board Assurance Statement provided at Annex 3 by 31 July 2026.**

For NHS trust chief executives, medical directors and chief nurses, there will be a chance to discuss this and broader issues in maternity and neonatal care when we come together in London on Tuesday 30 June.

Thank you for all you have already done in response to the Fuller recommendations to date. However, there is still more work to do. We owe it to those who have died, and to their families and loved ones to ensure the findings of the Donna Ockenden review, the HTA report on NUH, and the Fuller Inquiry recommendations lead to meaningful and lasting change.
Yours sincerely,

Duncan Burton
Chief Nursing Officer for England

Sarah-Jane Marsh
NHS England Chief Operating Officer

Annex 1 - Summary of national updates made or planned in response to the Fuller Inquiry

1. **NHS Premises Assurance Model (PAM)** (15 April 2026)

The NHS Premises Assurance Model (PAM) supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services and provides assurances that the estate is safe, efficient, effective and of high quality. The NHS Standard Contract requires providers to comply with the PAM. A new set of high-level self-assessment questions reflecting relevant recommendations made by the Fuller Inquiry has now been incorporated into the latest version of the PAM. The submission window for the NHS runs from 8 May 2026 to 8 September 2026.

For assurance by trust boards: Trusts should assure themselves against the latest version of the PAM self-assessment questions.

2. **Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services** (May 2023)

Health building notes (HBNs) give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities. Health Building Note 16-01: Facilities for mortuaries, including body stores and postmortem services was updated in 2023, to enhance levels of security, access and CCTV, however we will be providing further update during 2026 to provide additional guidance to NHS trusts on recommendations raised by the Fuller Inquiry.

For assurance by trust boards: Trusts should consider best practice guidance set out in the HBN for ongoing planning.

3. **Insightful provider board guide** (November 2024)

Trusts are reminded that the insightful provider board guide is intended to help boards to identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively. This guidance already references mortuary practices but will be updated later in 2026 and will incorporate relevant content to reflect Fuller findings and recommendations. It should be read alongside the Code of governance for NHS provider trusts (March 2026) and Guidance on good governance and collaboration (April 2023).
For assurance by trust boards: Trust boards should use the guidance provided to reflect and consider whether the leadership, culture, systems and processes they have in place are using information in the best way to lead their organisations effectively in respect of matters relating to mortuaries and body stores.

4. **Assessing provider capability: guidance for NHS Trust Boards** (August 2025)

Assessing provider capability: guidance for NHS trust boards provides a self assessment framework to strengthen boards' governance and assurance. These self-assessments are used by regional oversight teams along with their own views and information held by 3rd-party bodies (including the Human Tissue Authority) to take a view of management, governance and grip. This guidance is also due to be updated later in 2026.

For assurance by trust boards: As per Insightful provider board guide (see entry 3).

5. **Advanced Foundation Trust Programme** (12 November 2025)

For existing NHS foundation trusts and NHS trusts who wish to become advanced foundation trusts, the Advanced Foundation Trust Programme requires evidence that trusts applying for advanced foundation trust status have considered relevant insights and learning from inquiry recommendations and have implemented them or are in the process of implementing them (question 2, advanced foundation trust criteria – quality governance arrangements are effective in practice).

For assurance by trust boards: As per Insightful provider board guide (see entry 3).

6. **NHS Safeguarding accountability and assurance framework** (April 2026)

The NHS Safeguarding Accountability and Assurance Framework (SAAF) sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. This includes requirements for an executive lead for safeguarding. In April 2026, the SAAF was updated to include reference to the deceased. Trusts should also note this addition will require a supporting reference to be made in the annual report about safeguarding children, adults and children in care. This must be submitted to the trust board.

NHS England is also updating related training to include reference to the deceased. These updates will be made during 2026.

For assurance by trust boards: Providers must demonstrate that these updates to safeguarding are embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working.

In line with updates to the SAAF, executive leadership should now include oversight of arrangements for the deceased. Trust boards are encouraged to consider their

local arrangements accordingly. Executive leadership for safeguarding, estates and related security matters may vary according to local arrangements (for example, operating via a dual accountability between the executive lead for statutory safeguarding and the executive lead for estates) and trust boards should ensure this is clearly articulated.

Local take-up of safeguarding training and resources requires ongoing assurance by trusts.

7. Related Third Party Guidance

HTA Guidance

The Human Tissue Authority (HTA) Codes of Practice provide practical guidance to professionals carrying out activities within the scope of the HTA's remit, which includes licensed mortuary facilities in the NHS estate. This includes detail on the required appointment of a Designated Individual. The Human Tissue Authority have additionally published good practice guidance for those responsible for the dignity and care of the deceased. This is voluntary guidance and applicable to all settings, including unlicensed body stores.

Hospice UK Guidance

Hospice UK have several resources to support clinical and non-clinical staff in a hospice role. Their Care After Death guidance provides a comprehensive guide for all staff who are responsible for the care of a deceased adult.

Annex 2 – NHS specific Fuller Inquiry report recommendations and supporting guidance. Please refer to annex 1 for additional context on supporting guidance.

Recommendations 1 to 9 (relevant to security, CCTV, access and audit) The full text of these recommendations can be found in the Phase 2 Report (pp.264265).

Supporting guidance
NHS Premises Assurance Model (see entry 1 in Annex 1).

Health Building Note 16-01: Facilities for mortuaries, including body stores and postmortem services (see entry 2 in Annex 1).
Other third-party guidance: Human Tissue Authority code of practice and Human Tissue Authority voluntary guidance (see entry 7 in Annex 1).

Recommendations 10, 11, and 12 (relevant to the role of the Designated Individual)

The full text of these recommendations can be found in the Phase 2 Report (p.265).

Supporting guidance

Third party guidance: Human Tissue Authority guidance, including the role of the Designated Individual (see entry 7 in Annex 1).

Recommendations 13 and 14 (relevant to the role of the Mortuary Manager)

The full text of these recommendations can be found in the Phase 2 Report (pp.265266).

Supporting guidance

Local HR policies and resource allocations.

Recommendations 15, 16, 17 and 18 (relevant to the board assurance and reporting)

The full text of these recommendations can be found in the Phase 2 Report (pp.265266).

Supporting guidance

The Insightful provider board guide (see entry 3 in Annex 1). Assessing provider capability: guidance for NHS trust boards and third party information (see entry 4 in Annex 1).
Advanced Foundation Trust Programme (see entry 5 in Annex 1).

Recommendations 19, 20 and 21 (relevant to safeguarding)

The full text of these recommendations can be found in the Phase 2 Report (pp.266267).

Supporting guidance

NHS Safeguarding Accountability and Assurance Framework (see entry 6 in Annex 1).

Recommendations 24 and 25 (relevant to medical education settings) The full text of these recommendations can be found in the Phase 2 Report (pp.267268).

Supporting guidance

Where relevant to the NHS, these actions have been reflected in the NHS Premises Assurance Model (see entry 1 in Annex 1)

Recommendation 27 (relevant to hospice settings)

The full text of this recommendation can be found in the Phase 2 Report (p.268).

Supporting guidance

NHS trusts directly providing a hospice service that includes provision for either a mortuary or body store should be aware of wider updates, as set out in **annex 1**. Other related third-party guidance has also been updated in line with inquiry findings:

Hospice UK guidance (Care After Death) and Best practice guidance from the Human Tissue Authority (see entry 7 in Annex 1).

Recommendations 30 to 33 (relevant to ambulance policies and data)

The full text of these recommendations can be found in the Phase 2 Report (p.269).

Supporting guidance

The government's interim update sets out what action should be taken. A further update is expected in summer 2026.
In addition to the Government's interim update, ambulance trusts are individually responsible for introducing operational policies as described in the recommendation, and for ongoing monitoring of their use. Boards should assess compliance against these recommendations

Yorkshire Ambulance Service NHS Trust

APPENDIX 2: Clinical Safety Review

Clinical Safety Review

iPad EPR: Photo and Notes (within Assessment Module)

Directorate / Programme	Clinical Systems Development	**Project**	[Subject]
Director	Samantha Robinson	**Phase**	Delivery
Owner	Ola Zahran	**Version**	1.0
Authors	Michael Stead Paramedic Katie Rowe CSO	**Version issue date**	[Publish Date]

[Publish Date]
Published 20/01/2026

Document Management

Revision History

Version	Date	Summary of Changes
0.1	26/08/25	Photo Capture Hazard Workshop
0.2	17/11/25	Review Draft completed by Michael Stead
1.0	25/11/25	Reviewed by Katie Rowe CSO
1.1	20/01/2026	Final amendments by Katie Rowe and published for review

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Date	Version
Dave Bird	Lead Engineer		1.1
Anthony Onwutalobi	Business Analyst		1.1
Barbara Wallington	Business Analyst		1.1
Sian Registe	Senior Project Manager		1.1
Michael Stead	Paramedic		1.1
Samantha Robinson	Chief Information Officer		1.1

Approved by

This document must be approved by the following people:

Name	Title	Date	Version	Sign
Ola Zahran	Chief Technology Officer		1.1	
Tim Millington	Consultant Paramedic	23/03/26	1.1	

Related Resources

These documents provide additional information and are specifically referenced within this document.

Ref	Document Type	Title	
1	DCB0129 Standard Specification	DCB (SCCI) 0129 Clinical Risk Management: its Application in the Manufacture of Health IT Systems. 02/05/18.	
2	DCB0160 Standard Specification	DCB (SCCI) 0160 Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems. 02/05/18.	
3	EPR Hazard Log	EPR NG Hazard Log	iPad ePR Hazard Log
4	Hazard Workshop Minutes	Photo Capture Hazard Log Minutes	Hazard Workshop Meeting
6	DevOps Stories	User Story 13503 User Story 17232 User Story 13322 User Story 14028	
7	Consent policy	YAS Patient Consent Policy	
8	How to guide	How to Guide	

Summary Report

This Clinical Safety Review evaluates the Photo and Notes section within the Assessment module of the re-platformed iPad ePR system. The module supports structured capture of images of a scene or wound that has affected a patient's condition. This section has been assessed in a separate Clinical Safety case as it is a new function within the ePR and has not been utilised by the Trust in previous versions of EPR.

A Structured What-If Technique (SWIFT) analysis identified four key hazards:

Hazard	Risk Rating	
	Pre-control	Post-Control
Misuse of Photo Capture Function	Moderate (9)	Low (6)
Consent for Photo Capture	Low (6)	Low (2)
Failure to Sync Photos and Image Storage	Low (4)	Low (2)
Taking Image Causes Delay to Patient Care	Moderate (8)	Low (4)

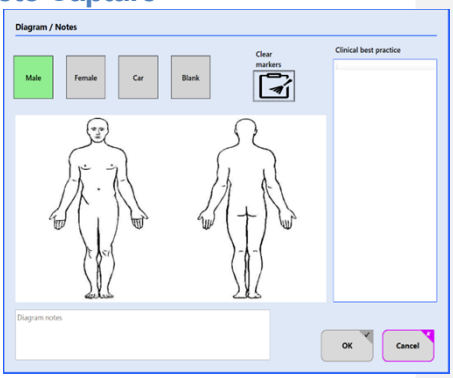
Each hazard was assessed using the DCB0129 risk classification matrix. Baseline mitigations include manual fallback procedures and the ability to only utilise the camera function within the ePR to upload images; these were further strengthened by system-level controls such as mandatory confirmation flows, audit logging, structured field prompts. All residual risks have been reduced to As Low As Reasonably Practicable (ALARP). No uncontrolled high-risk scenarios remain.

Commented [KR1]: Unverified identities?

The Photos and notes section of the iPad EPR system complies with DCB0129 requirements. Identified patient risks have been mitigated through a combination of system design and operational safeguards. The module is **considered safe for deployment** in its intended setting.

Table of Contents

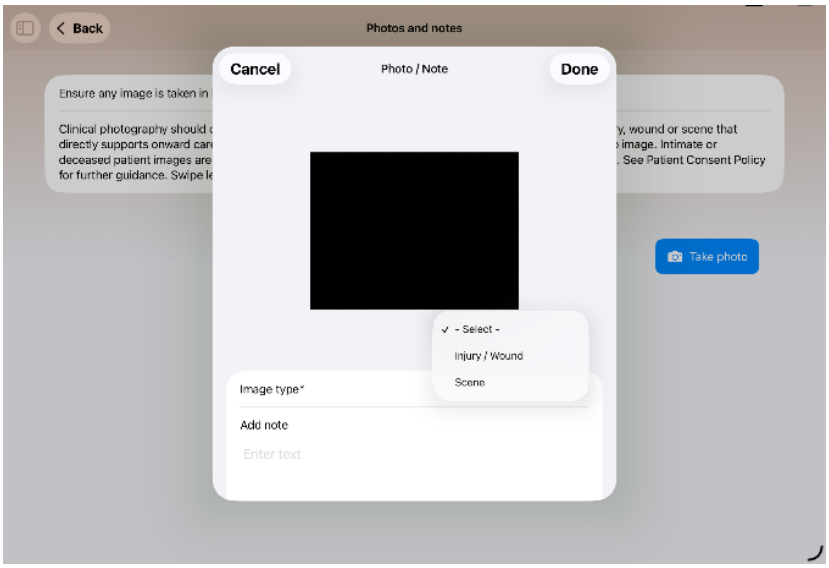
Evolution from annotated diagrams to Photo Capture



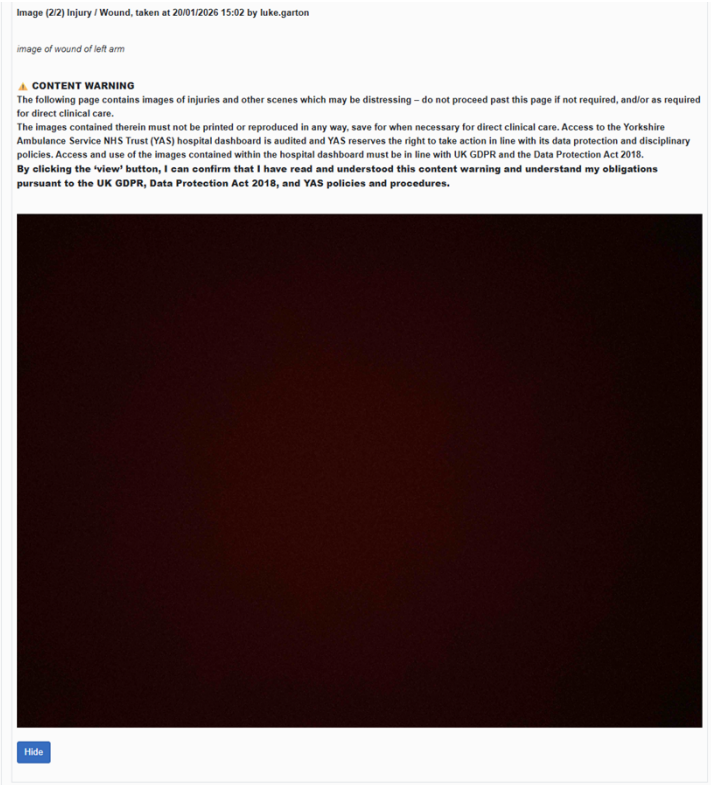
In classic ePR, clinicians documented injuries, wounds, or incident details using a diagrammatic interface (see diagram). This allowed users to select standardised templates (such as male, female, car, or blank), annotate diagrams with a marker, mandatory diagram free-text notes, and reference clinical best practice guidance (this is blank and of no value currently to the user). While this supported structured documentation without photographic images, the diagrammatic interface offered only limited clinical value. It provided basic visual representation but lacked the detail and accuracy required for comprehensive clinical assessment and effective communication of complex injuries or scenarios.

Due to these limitations, some users take photographs on their personal devices to supplement clinical documentation. This practice raised concerns around information governance and patient privacy, prompting an alert to staff and reference to the Patient Consent Policy. The use of personal devices risked images being stored insecurely, outside the patient record, and without proper audit or consent controls.

As part of the ePR replatforming, the introduction of a dedicated photo capture module was proposed and agreed. This new functionality aims to improve both patient care and governance by enabling secure, auditable image capture directly within the ePR. With photo capture integrated on one platform, images are not saved to the device itself but are transferred securely to the hospital and stored as part of the patient record. This ensures compliance with consent and privacy standards, supports clinical decision-making, and addresses the risks identified with previous workarounds.



The introduction of governed photo capture within the ePR represents a significant evolution from previous practice, where the absence of structured workflows meant that both image capture and image viewing carried risk. Consideration was given to receiving clinicians who may inadvertently view sensitive or distressing images without adequate warning or without clinical need. To mitigate this, the new system not only enforces mandatory image type selection and contextual notes at the point of capture, but also protects the receiving viewer through a controlled image viewing gateway: images are initially hidden behind a content warning wall displaying the image type, notes and a clear IG/GDPR advisory. The receiving clinician must actively choose to click “View” before image appears, confirming both that they understand the warning and that they are willing to proceed, ensuring sensitive imagery is viewed appropriately and deliberately within a governed clinical workflow.



The use of photo capture is governed by the YAS Patient Consent Policy (as agreed with the CCIO and Caldicott Guardian at the time Steven Dykes), on screen guidance and a 'how to guide'. It is also recommended that the Trust considers developing a dedicated clinical imagery policy to ensure robust standards for privacy, security, and clinical governance.

Component Overview

The photo capture module is a component of the ePR system, accessible through the Assessment section of the software. It can be utilised by users to capture images of the incident scene, accident or wounds a patient has suffered.
It allows for the presentation of visual information to support the patient assessment conducted by YAS clinicians utilising the in built iPad camera. The module also provides basic information for the clinicians regarding the considerations for information governance and the requirement for rationalising the need for photo capture. A maximum of five images can be uploaded to one ePR.

Functional Areas

The photo capture module is found within the assessment section of the ePR. It is a single area without subsections. On selecting the 'Photos and notes' section,

- *User is presented with information screen around the use of photo capture with brief text explaining the requirement for consent and guidance for when photo capture should be used.*
- A blue 'Take photo' button is present and when pressed, the in-built camera opens to take image.
- On first use of the camera within the ePR application, prompt will be asked to allow ePR to use the iPad camera.
- When an image is taken, the option to 'retake' or 'use photo' is prompted.
- If the 'use photo' is selected for use a mandatory drop down for image type is displayed. With options from; injury/wound or scene. The option to add notes in free text.
- If users wishes to cancel they are presented with warning that data will be lost and 'yes/no' to proceed
- User can swipe left on the image to delete before finalising ePR

All assessment data is timestamped and linked to the authoring clinician on finalisation. Records are stored locally on the device and synchronised to the central platform when connectivity permits. The interface uses native iOS components and adheres to platform accessibility and input standards

Integration and Interoperability

The photographs that are captured are encrypted and stored locally in the ePR database as binary strings. These are uploaded into the ePR application via the backend. Photographs are then removed from the device following finalisation and synchronised correctly. Put simply, the photographic data is not stored on the mobile device (iPad), ensuring they do not appear in the device photo gallery and do not have the ability to be shared outside of the ePR application.

The photos captured have no connection to PDS and are not shared back to any other external service other than the hospital dashboard.

Initially, this module will be monitored for usage, to assess the need for adjustments to server storage, initially a five-photograph limit imposed. When this analysis is completed, the data will be removed/destroyed.

Photographs uploaded are stored as a data within the ePR and are subject to the same viewing privileges allocated YAS staff have at this time. Post launch, an audit process regarding storage capacity and quantity of images to upload will take place to assess whether changes are required.

Clinical Relevance

The Photo Capture and Notes feature helps clinicians record clear, accurate visual information relevant to a patient's presentation or the scene they were treated in.
This visual information sits alongside a short, written description, helping the receiver to quickly understand what they're looking at without needing to rely only on verbal handovers.
The module uses structured fields, simple drop-down selections, and built-in safeguards to make sure the information recorded is accurate and appropriate. These include rules that prevent incomplete entries, indicators showing whether each section has been filled in, and timestamps so every photo can be traced back to the clinician who took it. This traceability supports auditing, investigation of clinical incidents, and compliance with legal and regulatory requirements.
All photos and notes form part of the clinical record. External regulators may also review this information as part of safety assurance under DCB0129.

Commented [MT2]: suggest reword... "record clear, accurate visual information relevant to the the patient's presentation or the scene in which they were treated..." (we might take photos of chronic wounds or tracking skin conditions eg cellulitis that might not be an injury as such

Methodology

The clinical safety assessment for the Photos and Notes (Photo Capture) feature was conducted using the Structured What If Technique (SWIFT). SWIFT supports systematic identification of clinical hazards by exploring plausible deviations from intended behaviour across routine, time critical and edge case usage scenarios. The assessment was informed by end to end workflow walkthroughs and review of user interface behaviour (including mandatory field logic, validation rules, prompts and navigation flows). Hazards were documented as hazardous scenarios with associated potential harms and were risk rated using the YAS risk classification matrix to determine pre and post control risk and confirm residual risk is reduced as low as reasonably practicable (ALARP).
The review focused on:

- Data entry workflows for each analysed section (e.g. capture of image, category selection, additional notes), including deletion prior to finalisation.
- Input validation rules, including mandatory fields, field constraints
- User navigation sequences and interaction patterns on the iPad interface, including time-pressured use in clinical settings.
- Interdependencies between this module and upstream/downstream clinical records (e.g. Patient Information module and inclusion within the wider clinical record for onward care).

Specific attention was given to foreseeable risks associated with consent/capacity, inappropriate image capture, deletion prior to finalisation, and ensuring photo capture does not delay patient care.

Review Inputs

The following artefacts were examined as part of the clinical safety analysis:

- User Interface (UI) walkthroughs of the module including Interaction logic and screen transitions
- Stakeholder walkthroughs via the Software Working Group
- Internal logic documentation (captured and tracked on the in-house Microsoft DevOps System) describing how identity is linked across records and synced to the central system
- External liaison (ambulance services): Peer engagement included review of external clinical photography policy material shared by NWAS and SCAS
- IG/legal liaison (on-screen warning text): The Photo Capture on-screen guidance/warning wording and receiving centres was reviewed with IG and legal: Helen Jones (Head of Risk & Assurance / DPO) and Benjamin Cowell (Deputy Head of Legal Services), with agreed wording captured via email
- Policies and staff guidance including Patient Consent Policy (Patient Consent Policy) and Staff Notice - Guidance on Clinical Photography (Guidance on Clinical Photography)

Stakeholder Involvement

Stakeholder engagement for Photo Capture included two formal hazard review sessions, peer benchmarking with other ambulance services on clinical photography policy, and IG/legal assurance of patient facing guidance text within the application.

- Initial Photo Capture hazard identification workshop – 26/08/2025 (iOS ePR injury site photos clinical hazard identification workshop). Attendees included: CCIO and Caldicott Guardian Steven Dykes. Documentation for the meeting can be found here: Photo Capture Hazard Workshop

- Follow up Hazard review – 08/12/2025 with key stakeholders. Documentation for this meeting can be found here: EPR Hazard Workshop

Scope of Assessment

This clinical safety assessment covers the functionality delivered by the photo and notes module within the assessment module iPad ePR system. It has been conducted in accordance with the scope and requirements of DCB0129/0160, which applies to Health IT systems used in the direct provision of care.

The purpose of this assessment is to identify and mitigate risks to patient safety arising from use of the module in clinical settings. It includes all functionality related to the structured capture of photographic data that informs diagnosis, treatment, and care planning during a patient episode.

This assessment is limited to the functionality implemented under the iPad Client workstream. It does not assess legacy platform functionality unless explicitly retained without change.

SWIFT Analysis

No.	What if Question	Answer	Possible Cause(s)	Hazardous Scenario	Potential Impact Harm	Controls	Story Refs
1.	What if inappropriate photos are taken?	Non-clinical or inappropriate images captured	- User error - Malicious intent - Lack of training/unclear guidance	Non-clinical / inappropriate images are captured and stored in the patient record. Images of intimate areas or deceased patients are taken contrary to guidance.	Patient dignity and privacy compromised; distress to patient/family. Information governance breach and reputational/legal risk.	1.On-screen guidance on the photo screen with explicit exclusions (intimate areas, deceased) and reference to Patient Consent Policy 2.On-screen guidance to obtain consent and document before capture; best-interest process where capacity is lacking. 3.Post-go-live review and user feedback to refine guidance. 4.Those accessing patient records are bound by there own duties in practice	#13503
2.	What if sensitive images are viewed inappropriately?	Sensitive photos accessed or viewed by staff not directly related to patient care	- Poor access control - Inappropriate storage of photo	Sensitive photos are accessed by staff not directly involved in the patient's care.	Breach of confidentiality and privacy; patient distress; disciplinary/IG action.	1.Images hidden behind a clear warning button on the receiving dashboard; require explicit click-through. 2.Comprehensive audit logging of access/attempts. 3. Those accessing patient records are bound by there own duties in practice 4. Images are taking via ePR and not stored on the device itself	#13503
3.	What ifi~~s~~ users doesn't know what they can/can't take photos of?	User takes unnecessary photos	- Lack of training - Unclear in-app guidance	Users take unnecessary or prohibited images due to lack of clarity.	Data minimisation breach; privacy risk; loss of trust; IG incidents.	1.Concise on-screen guidance stating what can/cannot be photographed for v1 (injury sites, wounds, RTC scenes) 2. Consent policy 3. How to guide	#13503
4.	What if patient cannot provide consent?	Images taken without valid patient consent	- Patient lacks capacity/unconscious/	Images captured without consent	Violation of consent principles and legal/ethical standards; complaints and claims.	1.On screen guidance informs users to gain consent where possible and document 2.Users having training to follow capacity assessment and best-interest decision-making; document rationale.	#13503

Commented [MT3]: is it worth mentioning the HCPC code of conduct here as a control? Do we limit photography to paramedics or registered clinicians only?

						3.If consent later refused prior to finalisation, delete images	
5.	What if patient would prefer to take photo on own phone?	Photos not recorded on EPR	- Patient wants to keep images - Patient not properly briefed by clinician on photo capture process, necessity and privacy information.	Clinical images are not recorded within EPR, reducing availability for onward care.	Loss of clinical context; reduced auditability.	1.If patient uses their own device, do not handle or store on staff devices; record in notes that patient-retained image was used.	
6.	What if receiving centre does not accept photos?	Photos not received for onward care	- Photographic representation of scene or wound not reviewed by receiving care provider - Technical, policy, or account issue	Receiving service cannot access/view images	Potential duplication of examinations; patient inconvenience.	1.Complete end-to-end testing with receiving sites prior to go-live; monitor ongoing. 2.Fallback to verbal handover if images are unavailable. 3.DATIX for rapid investigation and resolution.	
7.	What if taking a picture delays patient care?	Delay to treatment	- Crew spends excessive time capturing images, delaying treatment/transport.	Delay to Care	Clinical deterioration; missed intervention windows.	1.On-screen statement: "Do not allow photo capture to delay patient care."	#13503
8.	What if patient dies after picture is taken?	Image is capture of wound or scene is still part of patient assessment under YAS care.	- Image taken of wound then patient dies	Images exist for a patient who subsequently dies; or images taken of deceased contrary to policy.	Significant distress to family; reputational harm; complaints; IG risk.	1.Explicitly prohibit images of deceased patients in onscreen guidance. 2.If images were captured prior to death with consent/best-interest, retain within clinical record with restricted access and audit.	
9.	What if patient revokes consent?	Images can be deleted prior to finalising	- Patient agrees to photo capture but then refutes consent	Patient withdraws consent after images are taken.	Conflict between patient wishes and clinical record; potential complaints.	1.Allow deletion prior to finalisation/ submission 2. Communicate limitation with patient: once shared with receiving sites, images cannot be fully retracted and patient may exercise their GDPR rights	#13503
10.	What if patient is a minor?	Seek consent from responsible adult Consider Gillick Competence	- Photos are of a minor, with/without deemed competency to understand necessity of image requirements	Patient does not have ability to provide consent for image capture due to age or condition	Breach of MCA, safeguarding. IG and child protection SOP's.	1.Get parental consent in first instance and follow guidance as normal	#13503
11.	What if photos attached to incorrect patient ePR?	Clinician to consider all information and identity before photo capture.	- Details of patient incorrect - Multiple patient incident - Mismatch of information on spine	Images are associated with the wrong patient record due to misidentification or workflow error.	Wrong clinical decisions; privacy breach for both patients; IG incident.	1.Photos saved directly to EPR against current patient context; confirm patient details before capture.	#13503

		Option to delete prior to finalisation of EPR				2.User to raise incident via Datix if photos attached to incorrect patient	
12.	What if photo fails to synchronise between ePR and recipient?	Photo will not be reviewed by receiving treatment centre	- Loss of network connection - Device software issue(s) - User error	Image upload or delivery fails or is delayed; recipient cannot view in time.	Potential for repeat examinations; care delays.	1.Limit images per case to five to improve reliability 2.Fallback to verbal handover; service desk escalation. 3. Pre-go-live end-to-end testing with recipients; monitor failures post go-live. 4. Image will upload when connection returns	#13503 #13322
13	What if images persist on device storage?	Images remain on device cache/storage and are accessible outside EPR.	Device misconfiguration App crash mid-upload Local caching not purged	Images stored on device and accessible outside managed app	Privacy breach; IG incident; loss of trust	1.Images can only be captured in EPR and not uploaded from device 2. The photographs that are captured are encrypted and stored. Photographs are then removed from the device following finalisation and synchronised correctly	#13503
14	What if photo is received without contextual notes?	The receiving clinician may not have sufficient information to understand what the image rePResents or why it was captured.	- Clinician did not add contextual notes (notes field is optional). - Time critical environment leading to minimal documentation. - Assumption that the image content alone is self-explanatory. - Lack of training on when additional notes are beneficial.	A photograph is uploaded with the mandatory image type field completed (e.g., *injury/wound* or *scene*), but no accompanying notes. The receiving destination is unable to determine the clinical relevance, anatomical location, mechanism of injury, or associated findings solely from the image.	Misinterpretation of injury or clinical context. Delayed or incorrect assumptions during triage or assessment. Need for repeated examinations or questioning. Reduced value of the image as part of the clinical record. Possible IG concern if the image appears unclear or unnecessary without explanatory context.	1. Mandatory image type field and notes ensures a minimum level of classification. 2. Verbal handover used as fallback when clarification is required 3. Receiving centre is provided with image type and noted before opening the image	#13503

Commented [MT4]: via Datix?

Identified Hazards

Hazard ID	Hazard Type	SWIFT Q.	Hazard Title	Hazard Description	Harm
HAZ-EPR-1101	Inappropriate or sensitive image taken and/or viewed inappropriately	1,2,3	Misuse of Photo Capture Function	Clinician takes an inappropriate or sensitive image	Data breach, IG and safeguarding concerns.
HAZ-EPR-1102	Consent for photo not given/revoked	4,5,8,9,10	Consent for photo capture	Consent for a photo to be uploaded to EPR is not given, revoked or unable to be obtained due to condition or patient is a minor.	Continuity of care issues, IG and safeguarding concerns.
HAZ-EPR-1103	The receiving destination cannot see the uploaded images	6,11,12,13,14	Failure to sync photos and/or Storage of image	There is a network issue with syncing record to network or photos are uploaded to incorrect patient on ePR	Accuracy of patient record, continuity of care, IG and safeguarding concerns.
HAZ-EPR-1104	Delay to patient care	7	Taking an image causes a delay to patient care	The time taken for photo(s) delays time or treatment while in care of YAS.	Delay to patient care or to receiving destination, potentially fatal.

HAZ-EPR-1101 – Misuse of Photo Capture Function

Scenario
A clinician uses the photo capture function within the ePR but may not fully understand what constitutes an appropriate clinical image or may capture photos without sufficient contextual information. This could include:

- taking an inappropriate or sensitive image,
- capturing a photograph when a written description would have been adequate, or
- submitting an image with insufficient notes for onward clinical interpretation.

There is an additional risk that receiving clinicians may view sensitive images inappropriately, unless safeguards are in place to ensure they understand the nature of the content prior to accessing it.

Sequence of Events

1. Clinician opens the *Photos and Notes* section in the Assessment module.
2. On-screen prompts provide guidance on consent, IG requirements, and prohibited imagery.
3. Clinician selects Add Photo, opening the device camera.
4. Image is taken, with the option to *Retake* or *Use Photo*.
5. A mandatory Image Type field is presented and must be completed.
6. A mandatory freetext Notes field must be completed to provide clinical context.
7. The photo is finalised and committed to the clinical record.
8. Receiving clinician attempts to view the image:
    - The image is hidden behind a content warning wall,
    - The viewer sees image type and contextual notes before accessing the image,
    - A clearly displayed content warning explains that the image may be distressing or sensitive and outlines IG obligations,
    - The user must actively click “View”, confirming both:
        - (a) they wish to proceed, and
        - (b) they understand the IG and safeguarding responsibilities associated with viewing clinical imagery.

Commented [MT5]: unless doing so impacts patient care?

Harm
Inappropriate photos, unclear images, or images submitted without sufficient contextual information or viewed inappropriately can lead to safeguarding concerns, information governance breaches, misinterpretation of the patient’s condition, reduced clinical value for onward care, and potential delays or duplication in assessment and treatment.

Commented [MT6]: do we need to reiterate for time critical pts where this might cause delay that we accept this risk?

Existing Controls (Pre-Platform)

- Paper forms allowing written description of wounds/scenes
- Classic ePR allowed capture via diagrammatic interface
- Verbal handovers providing context and explanation

Pre-Control Rating

Pre-Control	Justification
Severity: 3 (Moderate)	Missed relevant information regarding a scene or wound can affect onward care. Improper sharing of inappropriate imagery can cause safeguarding and/or IG data breaches.
Likelihood: 3 (Possible)	May happen occasionally; reliant on user input and review; UI permits omissions.
Risk Rating: 9	**Moderate x Possible = 3 × 3 = 9**
Risk Level: Moderate	The absence of any governed mechanism to capture, store, or audit clinical photographs meant that images taken on personal devices could not be securely managed, monitored, or linked to consent processes, creating a possible likelihood of misuse, information governance breaches, and misinterpretation of patient information.

Additional Controls

- Mandatory image type selection for every photo.
- On-screen IG and consent guidance, including prohibited imagery.
- In app deletion available prior to finalising the record.
- Audit logging of all image capture, deletion and viewing activity.
- Images stored only within the ePR, never on the device.
- Secure transfer to receiving care providers.
- Workflow prompts to avoid delay to care.
- How-To Guide supporting appropriate use.
- Receiving-centre image-viewing safeguard:
  Sensitive images are initially hidden,
  Image type and contextual notes displayed first,
  A content warning wall outlines IG, GDPR, Data Protection Act obligations,
  Viewer must actively click “View” to confirm understanding and consent to proceed and view the image, this confirmation is explicitly recorded in the audit log.

Post-Control Rating

Post-Control	Justification
Severity: 3 (Moderate)	Missed relevant information regarding a scene or wound can affect onward care. Improper sharing of inappropriate imagery can cause safeguarding and/or IG data breaches.
Likelihood: 2 (Unlikely)	May happen occasionally; reliant on user input and review; UI permits omissions.
Risk Rating: 6	**Moderate x Unlikely = 3 × 2 = 6**
Risk Level: Low	With the introduction of the Photo Capture module, governed controls such as mandatory image-type classification, on-screen consent and IG guidance, audit logging, in-app deletion prior to finalisation, and clear guidance and workflow prompts now ensure that images are captured, stored, and transmitted securely within the clinical record, reducing the likelihood risk.

HAZ-EPR-1102 – Consent not obtained/revoked for Photo Capture

Scenario
Consent maybe gained or be gained then revoked by a patient such as a patient that absconds or expires within the care of the Trust. Consent of a minor is to be attained by a parent or responsible adult accompanying them while with YAS clinicians. Gillick competency of a minor must be understood and acknowledged when considering the use of digital imagery of a minor.

Sequence of Events

1. Clinician enters the Photos & Notes section.
2. On-screen guidance reminds user to obtain consent and avoid prohibited imagery.
3. Clinician proceeds to Add Photo.
4. Camera opens and a photo is taken.
5. User selects Use Photo and takes image
6. Consent may be:

   a) not obtained b) unable to be obtained (capacity/minor) c) later revoked.
7. User records consent or not
8. Photo remains in the assessment unless deleted before finalisation.
9. If not deleted prior to finalisation, image becomes part of the permanent clinical record and is sent to receiving organisations.

Harm
Capturing images without valid consent may lead to information governance breaches, safeguarding risks, loss of patient trust, complaints or legal escalation, and reduced clinical context for onward care if images must be deleted.

Existing Controls (Pre-Platform)

- Consent obtained for care as per YAS policy

Pre-Control Rating

Pre-Control	**Justification**
Severity: 3 (Moderate)	Images taken regarding a scene or wound without consent can affect onward care. Improper sharing of inappropriate imagery can cause safeguarding and/or IG data breaches.
Likelihood: 2 (Unlikely)	May happen occasionally; reliant on user assessment, input and review.
Risk Rating: 4	**Moderate x Unlikely = 3 × 2 = 6**
Risk Level: Low	Clinicians rely on paper forms and the classic ePR's diagrammatic interface to document wounds or scenes, supported by verbal handover, while some staff resorted to taking photographs on their own personal devices a workaround that created IG and consent risks.

Additional Controls

- Visual text prompts regarding consent and IG policy
- Audit log tracks confirmation action
- Images can be deleted if deemed inappropriate or consent not gained/revoked prior to finalisation
- User 'How to' guide available on photo capture screen

Post-Control Rating

Post-Control	**Justification**
Severity:3 Minor	Missing or incorrectly handled consent for clinical images can undermine onward care and create safeguarding or information-governance breaches if inappropriate imagery is shared.
Likelihood: 1 (Rare)	May happen occasionally; reliant on user input and review; UI permits omissions.
Risk Rating: 2	**Minor x Rare = 3 × 1 = 3**
Risk Level: Low	Clear on-screen consent and IG guidance, audit-logged confirmation actions, and the ability to delete images before finalising the ePR, the likelihood of capturing or retaining images without valid consent is reduced

HAZ-EPR-1103 – The receiving destination cannot see the uploaded images

Scenario
The iPad and/or ePR loses network connection or fails to synchronise with the recipient software/hardware. The recipient cannot see the uploaded images.

Sequence of Events

1. Clinician finalises ePR
2. ePR attempts to sync to network or the recipient
3. Synchronisation failure
4. System continues to attempt to reconnect/sync
5. If synchronisation failure occurs, recipient have process to follow to gain access to ePR manually

Harm
The inability to access relevant YAS documentation may result in lack of, or gaps in onward care. The reliance of a verbal handover may lead to missed or overlooked information relevant to patient care in the future.

Existing Controls (Pre-Platform)

- Paper forms with ability for written description of patient care journey with YAS.

- Verbal handovers covering key data.

Pre-Control Rating

Pre-Control	**Justification**
Severity: 2 Minor	Lack of correct documentation sharing can affect onward care.
Likelihood: 3 (Possible)	May happen occasionally; reliant on network connections and functionality of hardware/software.
Risk Rating:	**Minor x Possible = 2 × 3 = 6**
Risk Level: Moderate	Moderate risk due to potential clinical consequences

Additional Controls

- Constant automated process to reconnect to the Trust network
- Improved connectivity of Ipad vs Getach

Post-Control Rating

Post-Control	**Justification**
Severity:2 (Minor)	Ability to share documentation regarding patient journey is imperative to accurate and effective onward care.
Likelihood: 2 (Unlikely)	May happen occasionally; reliant on network connect and sustainability.
Risk Rating: 2	**Minor x Rare = 2 × 2 = 4**
Risk Level: Low	Care has been provided, images are supplementary

HAZ-EPR-1104 – Taking Image Causes Delay to Patient Care

Scenario

Specific clinical ~~wounds~~presentations or the events at the scene of an incident may benefit from being recorded as photographs for the receiving destination to understand and influence continued care. However, if an incident is time critical in nature, the act of taking and uploading relevant images and/or providing descriptive accompanying text may result in delayed treatment and or transport of a patient to a receiving destination.

Commented [MT7]: suggested re-word... "However, if an incident is time critical in nature, the act of taking and uploading relevant images, or providing descriptive accompanying text, may result in delayed.."

Sequence of Events

1. Clinician opens photos and notes to take photo or scene/wound/injury before attending to patient
2. Delay in patient care and potential harm to patient

Harm

The act of taking images of a scene or wound may divert the clinician from providing the required care or transporting a patient to a receiving destination. This action would cause the patients' right to Article 2 of the European Convention of Human Rights to be affected as well as contravene Trust policies and procedures.

YORKSHIRE AMBULANCE SERVICE NHS TRUST

Existing Controls (Pre-Platform)

- Paper forms with ability for written description of scenario and patient's condition.
- Verbal handovers covering key data.

Pre-Control Rating

Pre-Control	**Justification**
Severity:4 (Major)	Delay could cause patient harm
Likelihood: 2 (Unlikely)	Unlikely a crew member would delay care to capture a photo
Risk Rating:	**Major x Unlikely = 4 × 2 = 8**
Risk Level: Low	Risk due to potential clinical consequences and delayed onward care.

Additional Controls

- On screen warning to not allow photo capture to delay patient care
- Included in 'How to' guide

Post-Control Rating

Post-Control	**Justification**
Severity:4 (Major)	
Likelihood: 1 (Rare)	Should never happen. Rarely would a photograph be vital.
Risk Rating:	**Major x Rare = 4 × 1 = 4**
Risk Level: Low	Images taken regarding a scene or wound would not override the requirement to provide life-saving interventions or timely transport to a receiving destination.

Clinical Safety Officer (CSO) Review Summary

The Clinical Safety Officer (CSO) Review confirms that all risks associated with the Photo and notes within assessment module have been identified and appropriately mitigated. Risks such as inappropriate image capture, consent, or inadequate information governance have been addressed through agreed controls including mandatory fields, on-screen guidance, and comprehensive audit logging.

Following the application of these controls, the remaining risks meet the As Low As Reasonably Practicable (ALARP) standard required under DCB0129/DCB0160. The module now provides a consistent way to capture clinical images over current practice without introducing unacceptable clinical risk.

To strengthen practice further, the CSO recommends trust consideration of development of a formal policy or scope of practice to standardise how digital imagery should be used. However,

immediate safeguards including the consent policy, onscreen guidance, and the staff 'How To' guide are already in place and considered sufficient for deployment.

Optional Future Improvements / Recommendations

- Consideration of the development of a formal clinical photography policy or scope of practice to provide long-term consistency, governance, and clear expectations for staff.
- The addition of image type option (alongside injury/wound or scene) 'Other' with mandatory free text description field. Thus, to provide the ability to document other conditions or symptoms such as chronic skin conditions such as ulcers or cellulitis.
- Review and refine the wording used for receiving centres, with IG and Legal oversight, to ensure accuracy, clarity, and alignment with organisational standards.
- Explore additional appropriate use cases for photo capture, such as recording ECGs, patient provided information, or other clinically relevant documentation where imagery may further support patient care.
- Explore the possibility of role-based access to the use of digital imagery limited to YAS clinicians.

Safety Claim

This is justification for the following claim:

"The Photo Capture module has been developed in accordance with DCB0129 requirements. The risks to patients that may arise from its use have been identified, evaluated, and mitigated to a level that is as low as reasonably practicable (ALARP) for the intended clinical setting."

This claim is supported by structured hazard analysis, formal risk ratings, clinical walkthroughs, and confirmation that all key mitigations are implemented and active within the deployed module.

Next Steps

The following actions are recommended to ensure continued clinical safety assurance:

- **Hazard Log Maintenance:** The formal Hazard Log should be updated to reflect all identified hazards, including links to specific causes, implemented controls, and both pre- and post-control risk ratings. Any outstanding validation checks or draft entries should be completed prior to go-live.
- **Live Monitoring and Evaluation:** System usage should be monitored during early rollout and initial live deployment to detect unanticipated risks or workflow deviations. Audit trails, error logs, and structured clinician feedback should be analysed to assess the effectiveness of in-system controls and fallback processes.
- **Update to CSCR:** Findings from this Clinical Safety Review, including finalised hazard ratings and implemented mitigations, should be incorporated into the next

version of the Clinical Safety Case Report (CSCR). This will ensure end-to-end traceability and compliance with DCB0129 obligations.

- **Ongoing Clinical and Technical Collaboration:** Continued collaboration is required between clinical stakeholders, engineering teams, product managers, and operational leads. This will ensure that any design changes, user-reported issues, or workflow refinements are evaluated for clinical risk and appropriately mitigated.

Glossary

Term	Description
Clinical Risk	Combination of the severity of harm to a patient and the likelihood of occurrence of that harm.
Clinical Risk Estimation	Process used to assign values to the severity of harm to a patient and the likelihood of occurrence of that harm.
Clinical Risk Management	Systematic application of management policies, procedures, and practices to the tasks of analysing, evaluating, and controlling risk.
Clinical Risk Management Plan	A plan which documents how the Manufacturer will conduct clinical risk management of a Health IT System.
Clinical Safety	Freedom from unacceptable clinical risk to patients.
Clinical Safety Case	Accumulation and organization of product and business process documentation and supporting evidence, through the lifecycle of a Health IT System.
CSO	Clinical Safety Officer.
Deploying Organization	Organization that is deploying the health IT system used for a healthcare purpose.
Harm	Death, physical injury, psychological trauma and/or damage to the health or well-being of a patient.
Hazard	Potential source of harm to a patient.
Hazard Log	A mechanism for recording and communicating the on-going identification and resolution of hazards associated with a Health IT System.
Health IT System	Product used to provide electronic information for health or social care purposes. The product may be hardware, software, or a combination.

Health Organization	Organization within which a Health IT System is deployed or used for a healthcare purpose.
Likelihood	Measure of the occurrence of harm.
NHS Digital	The national information and technology partner to the health and social care system. NHS Digital is responsible for providing a range of digital services to the health and social care system in England.
Patient	A person who is the recipient of healthcare.
Release	A specific configuration of the software delivered to a Deploying organization by *System Name*.
Clinical Safety Case	The report that justifies achievement of the appropriate safety rating of the clinical system by means of a safety analysis, supported by safety arguments.
Safety Closure Report	The Safety Closure Report is raised in relation to the validation and assurance of the safety of a clinical system.
Safety Incident	Any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare.
Severity	Measure of the possible consequences of a hazard.

Appendix – Risk Classification Matrix

1.1 Risk Matrix

		SEVERITY				
		Minor	Significant	Considerable	Major	Catastrophic
LIKELIHOOD	Rare	1	2	3	4	5
	Unlikely	2	4	6	8	10
	Possible	3	6	9	12	15
	Likely	4	8	12	16	20
	Almost Certain	5	10	15	20	25

Risk Matrix Key - Severity

Score	Consequence	Description
1	NEGLIGIBLE	Minor injury not requiring first aid or no apparent injury
2	MINOR	Minor injury or illness, requiring minor intervention; No long-term consequences.
3	MODERATE	Moderate injury which impacts on an individual or a small number of people; Some degree of harm up to a year; RIDDOR/MHRA/agency reportable incident
4	MAJOR	Major injury leading to long-term incapacity/disability; Serious mismanagement of care with long-term effects
5	CATASTROPHIC	Death / life threatening harm; Multiple permanent injuries or irreversible health effects

Risk Matrix Key - Likelihood

Score	**Likelihood**	**Probability**	**Frequency**
1	RARE	Less than 0.001%(<1 in 100,000)	Event is theoretically possible but has not occurred. Would require multiple failures.
2	UNLIKELY	0.001% – 0.01% (1 in 100,000 – 1 in 10,000)	Could occur in exceptional or edge-case conditions. Not expected during normal use.
3	POSSIBLE	0.01% – 0.1% (1 in 10,000 – 1 in 1,000)	Reasonable chance under specific workflows or system states. May happen occasionally.
4	LIKELY	0.1% – 1% (1 in 1,000 – 1 in 100)	Anticipated to occur intermittently. Could recur under moderate usage patterns.
5	ALMOST CERTAIN	>1% (>1 in 100)	Expected to occur regularly under typical operating conditions. Likely monthly or more.

APPENDIX 3: Board Assurance Framework

Annex 3 – **Board Assurance Statement for NHS Provider Trusts.** Please return this assurance statement to the NHS England Inquiry Team by **31 July 2026** to: england.nhsinquiryteam@nhs.net

Assurance statement	**Confirmed (yes/no)**	**Additional comments or qualifications (optional)**
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.		Not applicable as the Trust do not store deceased bodies.
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.		Yes, we have reviewed against recommendations 30-33 and a review of the management of the deceased policy incorporating the new guidance will be presented to CGG in September 2026.
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.		Not applicable as the Trust do not store deceased bodies.
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to		Partially applicable, the policy on conveyance of the deceased is being reviewed to incorporate the recommendations on where staff should sit during conveyance and the security and dignity of the deceased in the ambulance.

address this and a plan is in place to implement them as a matter of urgency.	
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.	Not applicable as the Trust do not store deceased bodies.

Trust Name	Trust CEO/AO name	Date	Trust Chair name	Date
The Yorkshire Ambulance Service	Peter Reading	16.7.26	Martin Havenhand	16.7.26

APPENDIX 4 – Management of Deceased Patient Policy – separate attachment.

Board of Directors (in Public)
23 July 2026

Report Title	People Committee Chair's Report
Author (name and title)	Tabitha Arulampalam, Non-Executive Director and Chair of People Committee
Accountable Director	Mandy Wilcock, Director of People and Organisational Development
Previous committees/groups	N/A
Recommended action(s)	Assurance and Information
Purpose of the paper	The report provides highlights of the People Committee to provide assurance to the Trust Board.

Executive Summary

The People Committee took place on the 7 July 2026 and was quorate. This report presents key issues discussed and actions approved at that meeting to provide assurance to the Trust Board.

<u>The Committee focused on the following</u>

- Review of corporate risks including confirmation of two new risks:
  - Rising level of employment tribunals.
  - Safety Team capacity.
- Absence reduction plan progress update for quarter 1.
- Essential learning escalation Draft Framework.
- National Staff Survey update – quarter 1 engagement with staff.
- Sexual safety progress update.
- Business case – Future Occupational Health Services.
- People Committee Annual Report, Terms of Reference and self-assessment.

Recommendation(s)	The Trust Board is asked to note the contents of the report and the actions being taken.
Link to Board Assurance Framework Risks (Board and level 2 committees only)	6. Develop and sustain an open and positive workplace culture. 7. Support staff health and well-being effectively. 8. Deliver and sustain improvements in recruitment and retention. 9. Develop and sustain improvements in leadership and staff training and development.

Highlight Report

Report from: People Committee
Date of the meeting: 7 July 2026

Key discussion points at the meetings and matters to be escalated to board:
Alert:
The two new corporate risks: **Employment Tribunals (ET):** This was an emerging risk in the last report, the number of ET have increased and pose a financial and reputational threat to the Trust. The Trust deals with about 6 cases annually, currently it is 15, therefore it is now on the Risk Register with a score of 12. Ongoing work with solicitors to determine next steps addressing AI submitted claims and increased provision to allow for legal fees are in place as mitigating actions. **Safety Team capacity:** A review of the Safety Team's capacity has highlighted gaps for single points of failure and limited resilience. Funding was approved in October 2025 but a restructure has delayed recruitment, therefore the Trust carries a risk until these gaps are filled. This is now on the Risk Register with a score of 12. The job evaluation process for key roles has taken time but recruitment is expected to take place in the next quarter.
Advise:
Occupational Health Services (Business Case): The Committee approved the proposal to deliver a new model for Occupational Health Services from April 2027. The new model will bring the Occupational Immunisation Service in-house while extending the contract with the existing external Occupational Health provider for a further 12 months with strengthened contract management, allowing time to clarify the National Operating Model.
Assure:
Absence Reduction Plan: Sickness absence was reported as reducing, however, some of the reduction may be seasonal and could not yet be fully attributed to the actions being taken through the absence reduction work. The area specific targeted work and the broader Trust wide QI programme are being implemented. This is expected to show improvements later in the year as described in the plan. **Risk Assurance and BAF:** Strategic risk 8 (Deliver and sustain the required trajectories for staffing recruitment and retention) has been reduced from 15 (high) to 10 (moderate). This is based on a sustained positive position of staff recruitment and retention and staffing levels in the main service lines. **Essential Learning Escalation Draft Framework:** An Essential Learning Escalation Framework is being established to ensure a consistent, fair and proportional approach can be applied to manage non-compliance of mandatory and statutory training. Where non-compliance continues despite reasonable support the Framework provides clear escalation routes. **National Staff Survey Update – Quarter 1 Engagement with Staff:** This is complete and work is being done to construct an action plan from all the learning that has been gained. Three Trust wide priorities make up the next phase: • from 'voice' to 'influence';

- from ‘resilience’ to ‘sustainability;
- from ‘stability’ to ‘progression’;

Sexual safety progress update: This is becoming a well-established area of work with good governance and good partnership engagement. Strategic priorities have been agreed for 2026-27 and a measurement dashboard will demonstrate impact in the future.

Risks discussed:

Rising level of employment tribunals.
Safety Team capacity.
Deliver and sustain the required trajectories for staffing recruitment and retention.

New risks identified:

The Two risks that have been described in the Alert section.

Report completed by: Tabitha Arulampalam, Committee Chair
Date: 7 July 2026

Trust Board (in Public)
23 July 2026

Report Title	People and Organisational Development (OD) Directorate Highlight Report
Author	Suzanne Hartshorne, Deputy Director of People and Organisational Development Dawn Adams, Associate Director of People Development
Accountable Director	Mandy Wilcock, Director of People and Organisational Development
Previous committees/groups	N/A
Recommended action(s) (assurance, approval, information)	Information/Assurance
Purpose of the paper	The report provides a brief overview of the highlights, lowlights, and risks within the People and OD Directorate.

Executive Summary

The People and Organisational Development Directorate continues to deliver a broad programme of work to address the Trust's principal workforce risks relating to culture, staff wellbeing, recruitment and retention, and leadership development.

Progress continues through the YAS Together culture programme, staff survey action planning, diversity and inclusion initiatives, sexual safety improvements and employee relations activity. Most workforce equality indicators have improved, although challenges remain in inclusive recruitment, experiences of bullying, harassment and abuse, and career progression. Employee relations activity remains broadly stable, while Employment Tribunal activity continues to require close oversight.

Sickness absence remains above target and increased slightly during the quarter, making improvement a key organisational priority. A structured absence reduction programme is progressing, supported by targeted interventions focused on wellbeing, mental health, musculoskeletal health, leadership and workforce recovery.

Recruitment and retention performance remains strong, supporting a reduction in the associated Board Assurance Framework risk rating. Workforce stability has improved, vacancies have reduced and recruitment pipelines remain healthy, while governance arrangements for bank workers are being strengthened.

Leadership and development indicators remain positive, with sector-leading appraisal outcomes, strong senior leadership compliance, continued review of statutory and mandatory learning, and national recognition for apprenticeship provision.

Overall, the Directorate is making good progress in reducing workforce risks, although sickness absence, equality outcomes, apprenticeship completion rates and Employment Tribunal activity remain areas requiring sustained focus.

Recommendation(s)	The Trust Board are asked to note the contents of the paper.
Link to Board Assurance Framework Risks (board and level 2 committees only)	6. Develop and sustain an open and positive workplace culture. 7. Support staff health and well-being effectively. 8. Deliver and sustain improvements in recruitment and retention.

	9. Develop and sustain improvements in leadership and staff training and development.

People and Organisational Development Directorate - Highlight Report

1.0 INTRODUCTION

1.1 This paper updates the Board on the key achievements, and ongoing work, of the People and Organisational Development Directorate, focusing on mitigating four principal risks from the Board Assurance Framework: workplace culture, staff health and well-being, recruitment and retention, and leadership and training:

2.0 BACKGROUND

2.1 The NHS People Plan sets out the agenda, which supports how the NHS workforce can enable improvement of the patient experience. The Trust Strategy 'Great Care, Great People, Great Partner' supports the NHS People Plan and has a bold ambition 'Our People', that guides our work locally. These plans guide the Directorate as well as the day-to-day operations of leadership of an ambulance workforce.

2.2 The Board Assurance Framework (BAF) identifies four main risks linked to the Our People ambition, guiding the Directorate to address and resolve them. The four risks are:

#6 Ability to develop and sustain an open and positive workplace culture.

#7 Ability to support staff health and well-being effectively.

#8 Ability to deliver and sustain improvements in recruitment and retention.

#9 Ability to deliver and sustain improvements in leadership and staff training and development.

3.0 PEOPLE AND OD DIRECTORATE HIGHLIGHTS

3.1 The following sets out the key highlights of the directorate's work to mitigate and reduce the BAF risks.

#6 Ability to develop and sustain an open and positive workplace culture.

- **YAS Together** is focused on strengthening staff voice, embedding the Trust's behavioural framework, promoting psychological safety and supporting inclusive leadership through initiatives such as the Anti-Racism Charter and a new cultural awareness programme. Emphasis is being placed on ensuring operational colleagues are actively involved in shaping improvement priorities through engagement events, equality support networks and co-production approaches, e.g. strong participation and representation in an Anti-Racism consultation session. The programme is strongly aligned to the new NHS Staff Standards, including a focus on flexible working and staff experience. Overall, the cultural change programme remains on track to support the Trust's ambition of being a high-performing, inclusive and compassionate organisation.
- **2025 NHS Staff Survey:** Quarter one engagement cycle is complete, moving from results into structured action planning. Results have been shared across organisational forums and directorates, supported by Business Intelligence dashboard enhancements and further analysis on sexual safety, wellbeing, diversity and inclusion, and race equality. Directorates and teams have been supported to use the data to make local commitments, communicate transparently, and agree evaluation metrics focused on 'voice to influence' (ensuring staff feedback visibly shapes decisions), 'resilience to sustainability' (reducing workload pressure and improving safety and wellbeing) and 'stability to

progression' (strengthening career pathways, appraisal quality and development opportunities).

- **Diversity & Inclusion:** Workforce Race and Disability Equality Standards data was submitted meeting the 31 May statutory deadline. The majority of metrics have improved, although challenges remain in inclusive recruitment, experiences of bullying, harassment and abuse, and career progression. The Equality Support Networks have seen leadership changes as 'terms of office' come to an end although continued with strong joint working on station visits, cultural events and resources, a HQ Pride event, and automated membership processes. Analysis of the Lord Mann Review and NHS England immediate actions show good alignment with current practices and ongoing improvement work, e.g. development of Anti-Racism Charter, support resources including case studies and planned rollout of culture awareness sessions. Adoption of the Race and Health Observatory Seven Anti-Racism Principles as well as the Government definition of anti-Muslim hostility is in progress.
- **Sexual Safety:** The Trust continues to strengthen its approach to sexual safety through a comprehensive programme of governance, learning, prevention and cultural improvement. Oversight is provided through the Sexual Safety and Domestic Abuse Strategic Steering Group, which brings together insight from safeguarding, people processes, Freedom to Speak Up, trade unions and lived experience to drive organisational learning and improvement. The programme has matured beyond individual case management to focus on wider cultural change, workforce development and the prevention of inappropriate behaviour. A structured outcomes framework is being developed to strengthen assurance and demonstrate impact. Learning from sexual safety concerns, safeguarding cases and external developments is regularly reviewed to identify themes and inform improvements to policies, processes and staff support. Targeted communications, awareness campaigns and the Trust's Sexual Safety Charter continue to reinforce expected standards of behaviour and encourage colleagues to speak up. This work reflects the Trust's commitment to providing a safe, respectful and inclusive environment for staff, learners, volunteers, patients and the public.
- **Employee Relations** activity across the Trust remains broadly stable, with disciplinary, dignity at work, performance and sexual safety cases generally in line with levels reported by other ambulance services. Governance arrangements through the Professional Standards Panel continue to provide consistent oversight of key workforce decisions, while learning from disciplinary, sexual safety and recruitment-related cases has informed improvements to organisational processes and risk management. Employment Tribunal activity remains a significant area of focus, with 16 live cases during the quarter. However, the Trust successfully defended three cases, providing some confidence in the robustness of decision-making and case management arrangements. Improvement work continues to focus on reducing avoidable harm, encouraging earlier and more informal resolution of concerns, strengthening partnership working, preparing for legislative change, enhancing staff experience and maintaining a strong organisational commitment to sexual safety, fairness and accountability.

#7 Ability to support staff health and well-being effectively.

- **Sickness Absence:** The Trust's sickness rate deteriorated slightly increasing from 7.6% in April 2026 to 7.7% in June 2026 and remains above the 7.1% target. Given the concerning levels of absence, reducing absence remains a key Trust priority. A structured improvement programme has moved into the design and implementation phase, informed by data analysis, staff engagement and

stakeholder workshops. Six priority areas have been identified: leadership and culture, mental health and wellbeing, manual handling and musculoskeletal health, systems and processes, fatigue and recovery, and flexible, fair rostering. Planning is underway for pilot interventions to raise awareness and reduce musculoskeletal injury-related harm. A survey and review of existing resources have informed the prevention and recovery pathway within the absence management priority. Targeted operational interventions include enhanced psychological support, wellbeing and resilience initiatives, improved manual handling practice, BackTrack wearable technology to reduce injuries, and early referral to Health & Fitness Advisors for advice and recovery support. Early outcomes are encouraging, with evaluation continuing to identify and scale effective interventions that support sustainable improvements in staff wellbeing, attendance and patient care.

- **Health and Wellbeing:** Progress against the approved Health and Wellbeing plan 2026/27 is on track. Following completion of a comprehensive business case, work is now underway to extend the existing occupational health (OH) services contract and bring the management of occupational immunisations in-house.
- **Occupational Health:** Work continues to improve the quality and appropriateness of OH referrals and to reduce the associated cancellation costs, which have seen a slight increase in Q1 after a steady decline. To further support improvement efforts, work is due to start on the extension to existing OH service provision in readiness for 2027/28 with more rigour to contract management.

#8 Ability to deliver and sustain improvements in recruitment and retention.

- **Recruitment and retention:** Recruitment remains strong for Remote Patient Care, Ambulance Support Workers, and Paramedic programmes with a clear alignment with the Trust workforce plan. Although the Trust is nearly at full establishment overall, there are still vacancies in certain areas. Specifically, Integrated Urgent Care has a vacancy rate of 4.9%, Emergency Operations Centre stands at 9.7%, with 999 Operations currently exceeding their establishment by -0.8%. Turnover remains stable at a healthy 7.8% although, for IUC, it has remained high at 22.1%. Strengthened recruitment pipelines, improved retention, workforce stability and resolved staffing gaps justifies a reduction in the Board Assurance Framework risk rating from 15 to 10. The People Committee supported this reduction.
- **External Paramedic Recruitment:** A revised workforce requirement of 66-92 external Paramedics has been approved (previously 150). A strengthened recruitment and selection process including ECG Interpretation, Clinical Skills assessment and values-based interview has seen lower than anticipated pass rates. Resit opportunities have been offered for the knowledge and skills elements with 60 conditional offers made (24% of applicants). Further recruitment activity is ongoing where 66 minimum requirement is expected to be achieved. A series of six meetings have taken place with Higher Education Institute (HEI) partners to discuss the results, support for graduates who have not been successful and programme enhancements to ensure readiness for practice. A lessons-learned review on the newly implemented process is underway, using a Quality Improvement (QI) approach to evaluate the process and inform future campaigns.
- **Bank workers:** To address the corporate risk, a working group is reviewing the Trust's procedures for managing bank workers. This includes recruitment and exit processes, mandatory training, statutory sick pay entitlement, contract status, and entitlements. This will ensure robust processes and governance for safe,

compliant management of bank workers and support compliance with the Employment Rights Act 2025.

#9 Ability to deliver and sustain improvements in leadership and staff training and development.

- **Appraisal and Career Conversations:** YAS appraisal quality remains strong, with an average 2025/26 rating of 8.9/10, consistent with the previous year. The National NHS Staff Survey appraisal score increased from 4.0 to 4.3, placing YAS top of sector for the second year running. Staff satisfaction is high for preparation, environment, time, manager support, and quality of conversation, with scores around 89–90%. Improvement areas remain as appraisals need to better support job improvement, clear objective-setting, and feeling valued. The Appraisal Audit 2025 has led to updates in policy, templates, notifications, training, quality assurance, reporting, and escalation processes. Next steps focus on promoting quality resources, increasing survey responses, supporting managers, and reducing capacity barriers to meaningful appraisal conversations.
- **Senior Leadership Community (SLC) appraisal and career conversation window** ran across April to June with 92.1% compliance (14/07/26) with 3 directorates at 100%. Active discussions are ongoing with the managers of the 16 appraisals outstanding to provide support with completion. The Performance Review meetings actively monitor both appraisal and SLC compliance rates and plans to achieve timely completions.
- **Essential Learning Oversight Group (ELOG):** A key priority in 2026/27, transition year for statutory and mandatory learning as the framework is awaiting publication and the new nationally mandated learning is developed for release in April 2027, is a critical review of all locally mandated statutory and mandatory learning. Adopting the approach used for the national review, a three-stage Gateway process is being applied. Subject Matter Experts have been engaged and asked to submit gateway proposal for learning they wish to continue in 2027/28.
- **Apprenticeships:** Top 100 Apprenticeship Employers of the Year (Sunday Times) status was retained with YAS achieving #54. Retaining Top 100 status is part of our People Bold Ambition. This represents a reduction in our standing from 2025 at #12 which reflects the reduced number of Ambulance Support Workers new starters. London and North West Ambulance Services also retained their status but with a reduced ranking. Apprentices past their planned end date remains a focus, with a new Apprenticeship Management Standard Operating Procedure developed. This provides clear procedures for supporting apprentices fairly whilst protecting the Academy's funding and regulatory status.

4.0 CONCLUSION

4.1 The work of the Directorate aims to reduce the risks set out in the Board Assurance Framework as well as meet the Trust’s bold ambitions and NHS People Plan.

4.2 We are committed to improving the staff experience to ensure our patients get the ‘Best Care’ possible. We know that there is much more we can do to ensure they come to work and give their best on every shift. The above work demonstrates our work programme is extensive and wide-ranging, and we will strive to ensure that our people can thrive at every opportunity.

5.0 RECOMMENDATION

The Board are asked to note the contents of the paper.

People and OD Directorate - Risks aligned to the People Committee

Key issues/Risks to address	Actions implemented	Further actions to be undertaken
Sickness Absence – Whilst absence is slowly improving, it remains above 7%; hence a potential patient safety risk, if there are insufficient staff to support demand. In addition, the Trust target of 7.1% has not been achieved.	• The Absence Reduction Delivery Group, co-chaired by the Deputy Director of People and OD and the Associate Director of Quality Improvement and Safety, includes senior leaders from all operational areas to proactively manage plans. • The Priority 3 workstreams are progressing well with PMO supported plans on track for delivery. • The 4 QI-led projects arising from the listening exercise that took place in March 2026, are in test and learn phases; Leadership and Culture, Mental health and wellbeing, Moving and Handling, MSK and Physical Health, Data, Systems and Process Enablement.	• The Alternative Duties platform is undergoing User Acceptance Testing for a 'soft' release in August 2026. • The Attendance Management Policy is under review to ensure absence is being robustly managed with a clear process. The review will consider learning from the manager workshops held as part of the QI-led absence programme of work. • A review of recording absence on Trust systems is taking place to ensure this is efficient, without duplication of data.
Number of apprentices past their planned end date continues to be above the 15% threshold monitored by the Education and Skills Funding Agency resulting in workforce not progressing through the pipeline and financial risk of levy clawback. 48.28% ASW apprentices (n=56) 36.67% AAP apprentices (n=44)	• BI dashboard of individual apprentice performance against expected completion. • Implemented revised progress measures with apprentices put at risk of withdrawal for lack of progress, staged supportive process. • Monitoring of all apprentices on new extended programmes (ASW & AAP) to early identify any issues.	• Implement Apprenticeship Management SOP on approval. • Learning from the in-house Dyslexia Assessor capability to support SEND learners and reduce reliance on external provision. • Undertake a review of SEND resource requirements to strengthen support for learners, optimise in-house expertise and capacity, and reduce reliance on external provision where appropriate. • Progress Apprenticeship Support Lead post and local area leads.

Key issues/Risks to address	Actions implemented	Further actions to be undertaken
The Trust lacks systematic approach to managing bank staff including the recruitment, management, and leavers processes. Whilst the potential risks are to essential learning compliance and the implications for health and safety, safeguarding and clinical care overall. There are also risks to employment rights, regulatory compliance, clinical care and patient safety.	• Communicated entitlement for Statutory Sick Pay from 6 April, new entitlement also applies to bank workers. • Monitoring introduction of the Employment Rights Act (ERA) 2025 and identified the impact on Trust HR policies. • Created plan for updating all HR policies. • Identified inactive bank workers in ESR and GRS, in preparation for removing inactive workers.	• Continue to monitor introduction of ERA in 2026/27 and reflect changes in Trust policies and processes. • To identify bank workers not compliant with essential learning and work with 999 managers to agree next steps. • Working with departments to identify future requirements for bank workers, e.g. volume, activity and StatMand compliance requirements.
Employment Tribunals are significantly high, which brings risks regarding Trust reputation, financial risk due to increased legal fees.	• Provisions have been made in the Trust accounts to be able fund increased legal fees and potential awards. • Cases have clear direction and monitoring from Hill Dickinson. • A Disciplinary improvement plan is being progressed to support learning from cases, and quality of processes. • Given the significant number of cases that relate to disability discrimination, work to support workplace adjustments and alternative duties are part of the sickness absence work. • The Equality and Diversity action plan also supports culture change to reduce risk in this area.	• Work on workplace adjustments under Priority 3 in the Trust business plan continues and is on track for delivery. • Learning from 3 successfully defended cases will be incorporated into our approach going forwards. • The Absence Reduction work programme is progressing with a training workstream to ensure managers are compassionate in their approach, whilst robustly managing absence.

NHS Yorkshire Ambulance Service NHS Trust

Report Title	Lord Mann Review & NHS England Actions 2026
Author	Kirti Patel, Diversity & Inclusion Advisor Dawn Adams, Associate Director of People Development
Accountable Director	Mandy Wilcock, Director of People and Organisational Development
Previous committees/groups	None
Recommended action(s)	Approval
Purpose of the paper	This paper sets out the immediate actions requested by NHS England following the publication of the Lord Mann Review and provides an assessment of the Trust's current position, areas requiring further development, and proposed next steps.

Executive Summary

NHS England has written to all NHS organisations requesting a series of immediate actions following publication of the Lord Mann Review. These actions are intended to strengthen organisational approaches to tackling antisemitism, anti-Muslim hostility and all forms of racism within the NHS. The letter requests confirmation of organisational adoption of the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism and the Government definition of anti-Muslim hostility by 31 July 2026.

An initial review indicates that Yorkshire Ambulance Service is well aligned with many of the requirements through existing work programmes, including the Anti-Racism Charter, Anti-Discrimination Statement, Behavioural Framework, Workforce Race Equality Standards (WRES) action planning, Equality Support Network engagement and wider organisational culture initiatives.

The review has identified several areas requiring confirmation, further development or formal adoption. These include the adoption of the NHS Race and Health Observatory Seven Anti-Racism Principles and the Government definition of anti-Muslim hostility, preparation to implement the recently published NHS Staff Standards and NHS anti-racism training on publication and strengthening arrangements for monitoring and reporting progress against anti-racism activity.

Subject to approval, confirmation of the adoption of the definitions of antisemitism and anti-Muslim hostility will be submitted to meet the 31 July 2026 deadline.

Recommendation(s)	The Trust Board is asked to: a) Note the current YAS alignment with the NHS England immediate actions. b) Endorse the adoption of NHS Seven Anti-Racism Principles and the Government definition of anti-Muslim hostility. c) Support the proposed next steps.

Link to Board Assurance Framework Risks (board and level 2 committees only)	6. Develop and sustain an open and positive workplace culture. 9. Develop and sustain improvements in leadership and staff training and development. 11. Collaborate effectively to improve population health and reduce health inequalities.

Lord Mann Review & NHS England Actions 2026

1.0 INTRODUCTION

1.1 The Lord Mann Review, published on 4 June 2026, examined incidents of antisemitism within the NHS and made a series of recommendations for NHS organisations aimed at improving services and ensuring safety for all patients and staff (Appendix A).

1.2 NHS England has accepted the recommendations and requested immediate action from all NHS organisations. These actions focus on organisational culture, anti-racism, workforce training, governance, community engagement and monitoring of race-related inequalities.

1.3 NHS Trusts are required to confirm to NHS England by 31 July 2026, via an MS Form, the adoption of two specific definitions; International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism and the Government definition of anti-Muslim hostility.

1.4 This paper sets out the immediate actions requested by NHS England following the publication of the Lord Mann Review, and provides an assessment of the Trust's current position, areas requiring further development, and proposed next steps.

2.0 CURRENT POSITION

2.1 Appendix B sets out the NHS England immediate actions including an initial appraisal of the progress of YAS against these requirements. The actions relate to strengthening assurance, formalising commitments, implementing national requirements, and enhancing communication, engagement and reporting arrangements. The YAS appraisal shows overall strong partial alignment through existing anti-racism, equality, culture and workforce initiatives and ongoing programmes of work.

2.2 One immediate action is the adoption of the NHS Race and Health Observatory Seven Anti-Racism Principles, which is new to YAS. Appendix C is a summary infographic of the seven principles. An initial review of the principles indicates broad alignment between existing Trust commitments and the principles of leadership, community engagement, data, evaluation and anti-racist practice adopted by YAS. The seven anti-racism principles are:

- Demonstrate leadership by naming racism
- Understand and acknowledge
- Meaningfully involve racially minoritised individuals and communities
- Collect and publish data
- Identify racial bias
- Apply a race critical lens
- Evaluate and reflect.

2.3 The NHSE actions include expectations regarding implementation of the NHS England Staff Standards, recently published on 6 July 2026. A separate paper will be presented to TEG to appraise YAS' current position against these standards with an action plan for improvement to ensure the requirements are met. The YAS position is good to strong. The NHS Staff Standards include:

- Line management.
- Health and wellbeing.
- Violence prevention and reduction.
- Championing sexual safety.

- Tackling racism.
- Promoting flexible working.

2.4 In the same way Trusts were asked to adopt the International Holocaust Remembrance Alliance (IHRA) definition of Antisemitism (YAS adopted in December 2025), Trusts are asked to adopt the Government definition of anti-Muslim hostility. This is new for YAS with no current definition in place hence the 'not aligned' self-assessment.

The UK government's non-statutory definition of anti-Muslim hostility states:

"Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.

It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.

It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life."

3.0 GAPS AND AREAS REQUIRING FURTHER WORK

3.1 For the immediate actions which are not aligned or partially aligned, there is strong intent and correlation with the YAS Strategy, existing practices and ongoing development work.

3.2 There are two elements that require Board approval in terms of a strategic intent and Trust position; adoption of the NHS Race and Health Observatory Seven Anti-Racism Principles and the Government definition of anti-Muslim hostility.

3.3 Further work is also required to strengthen arrangements for monitoring, reporting and communicating progress against anti-racism activity, ensuring that colleagues, staff representatives, patients and communities remain informed and appropriately engaged in future developments. Existing governance and reporting mechanisms provide a strong foundation; however, opportunities exist to further enhance organisational assurance and oversight in line with the recommendations arising from the Lord Mann Review.

4.0 PROPOSED NEXT STEPS

4.1 To ensure compliance with the NHS England expectations and immediate actions to meet the Lord Mann Review, the following next steps are proposed:

- Seek Board approval subject to TEG endorsement of the 7 Anti-Racism Principles and the Anti-Muslim Hostility definition (Director of People by 31 July 2026)
- Embed commitment of 7 Anti-Racism Principles and definitions of Antisemitism and Anti-Muslim Hostility into existing Anti-Racism culture

development work (Associate Director of People Development by 30 September 2026)

- Establish a programme of work as part of the EDI Action Plan objective "Publish Anti-Racism Charter and supporting resources", engaging with relevant stakeholders, to address all Lord Mann Review and NHSE immediate actions (Associate Director of People Development by 30 September 2026)
- Provide updates and assurance through the governance structure of Diversity & Inclusion Steering Group, People & Culture Group, People Committee and Trust Board including impact metrics (Diversity & Inclusion Team, quarterly).

4.2 These next steps will support the continued development of the Trust's anti-racism agenda and wider commitment to creating an inclusive workplace culture.

4.3 Delivery of the immediate actions will require collaborative working across the Trust including Service Line Leads, Corporate Communications, Corporate Governance, Violence Prevention and Reduction, Freedom to Speak Up, Equality Support Networks in particularly the Race Equality Network, Trade Unions, YAS Academy, and the YAS Together culture development programme.

5.0 RISKS

5.1 Given the good to strong alignment of the current YAS strategic approach and practices and the planned improvement work, the risk of non-compliance is low. The key risk relates to the NHS England requirement to declare adoption of the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism (adopted December 2025) and the Government definition of anti-Muslim hostility. The latter requires Trust Executive Group endorsement and Trust Board approval prior to 31 July 2026.

5.2 If the Trust does not implement the required actions, then this could limit YAS' ability to demonstrate progress in tackling racism and improving the experience of staff from ethnically diverse backgrounds, resulting in a disproportionate impact on patient and staff experiences and the quality of care provided.

5.3 Some NHS England immediate actions are dependent on the publication of national anti-racism learning materials and further implementation guidance. Strong engagement will continue with the national statutory and mandatory training reform work to ensure YAS is ready to implement on release and meet the competency expectations.

6.0 RECOMMENDATIONS

The Trust Board is asked to:

a) Note the current YAS alignment with the NHS England immediate actions.
b) Endorse the adoption of NHS Seven Anti-Racism Principles and the Government definition of anti-Muslim hostility.
c) Support the proposed next steps.

7.0 APPENDICES

Appendix A - Lord Mann review of antisemitism and other forms of racism in the NHS and healthcare regulatory system - GOV.UK
Appendix B – Assessment of NHS England Requirements and Organisational Response
Appendix C - NHS Race and Health Observatory, Seven Anti-Racism Principles
Appendix D – Letter to NHS Leaders following publication of the Lord Mann Review

Appendix A; Lord Mann review of antisemitism and other forms of racism in the NHS and healthcare regulatory system - GOV.UK

Appendix B; Assessment of NHS England Requirements and Organisational Response

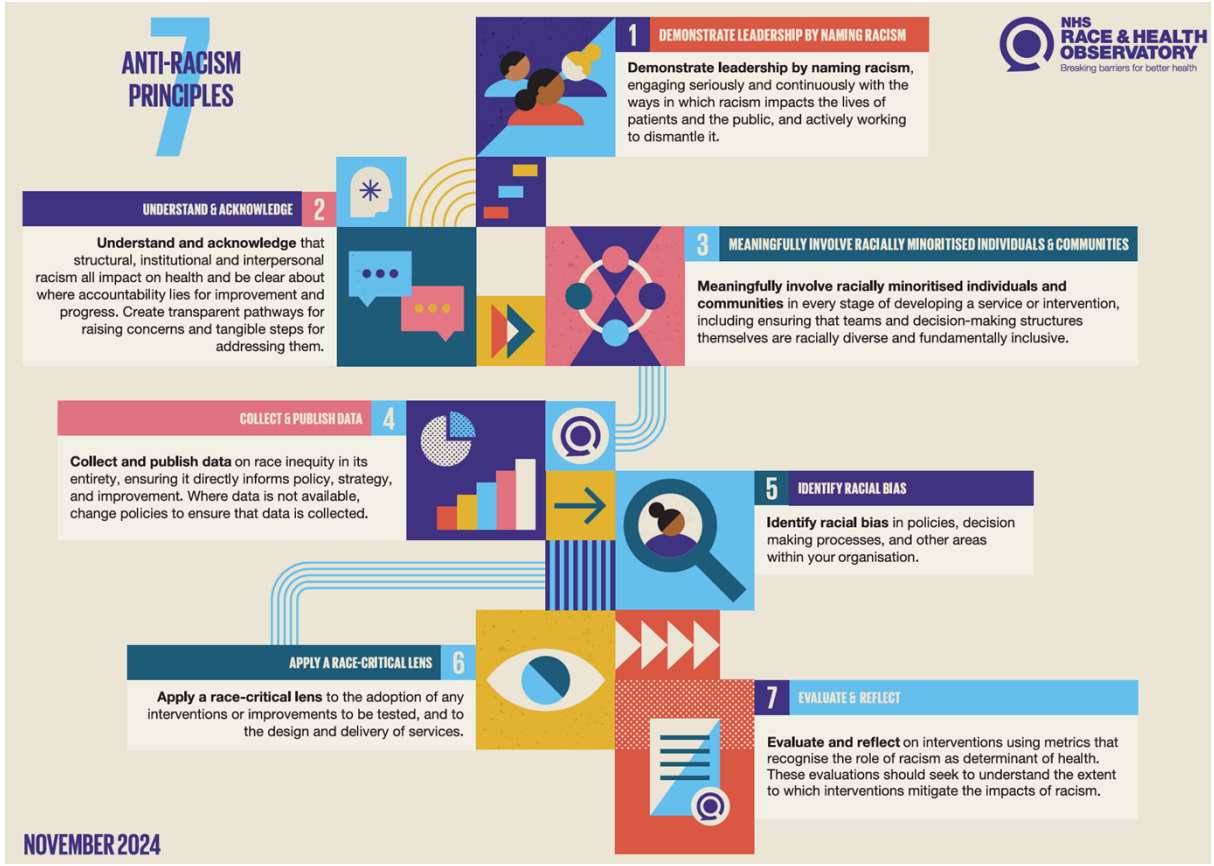
NHS England Requirement	Alignment Status	Current Position	Gaps/Further Work Required	Governance
A. Sign up to the NHS Race and Health Observatory Seven Anti-Racism Principles Seven Anti-Racism Principles and Briefings - NHS – Race and Health Observatory	Partially aligned	Established anti-racism commitments through: • Anti-discrimination statement and Behavioural Framework • Equality, Diversity and Inclusion action plan including Anti-racism objective and cultural awareness rollout • Strong reporting routes with Professional Standards Panel • WRES data and action planning • Established Race Equality Network • Established Equality Impact Assessments	• Formally sign-up to Seven Anti-Racism Principles • Finalise and publish Anti-Racism Charter with staff and manager guidance • Launch 'See Something Wrong, Do Something Right' call to action	• Diversity & Inclusion Steering Group • People & Culture Group • YAS Together Programme Group
B. Implement the Violence Prevention and Reduction Standard, including data capture and targeted improvement activity NHS staff standards: detailed requirements for employers - GOV.UK	Partially aligned	• Violence Prevention & Reduction incident reporting processes with data analysis • VPR prioritised improvement objectives including use of Body Worn Cameras	• Ensure data capture, monitoring and analysis of incidents includes incidents of racism, antisemitism, anti-Muslim hostility and other protected characteristics	• Violence Prevention Reduction Strategic Group • People & Culture Group • NHS Oversight Framework

NHS England Requirement	Alignment Status	Current Position	Gaps/Further Work Required	Governance
C. Prepare to implement the NHS Staff Standards NHS staff standards: detailed requirements for employers - GOV.UK	Aligned	• Preparation to implement the NHS Staff Standards is core business in some instances (e.g. health and wellbeing, championing sexual safety) and improvement objectives in others (e.g. anti-racism and flexible working). • Strong engagement with Leadership & Management Framework development work with good alignment.	• Assessment of current YAS position against the NHS Staff Standards with prioritised plan to address identified gaps – TEG paper to be presented at a future meeting	• YAS Together Programme Board
D. Adopt the Government definition of anti-Muslim hostility A Definition of Anti-Muslim Hostility - GOV.UK	Not aligned	• Anti-discrimination statement sets out a clear position regarding not tolerating discrimination in any form	• Anti-Muslim hostility not specifically stated or defined • Make explicit as part of the Anti-Racism Charter and case study examples	• Diversity & Inclusion Steering Group • People & Culture Group • YAS Together Programme Group
E. Ensure all staff complete the NHS Core Skills Framework Equality, Diversity and Human Rights module	Aligned	• NHS EDHR eLearning module mandated for all staff • 95.57% compliance rate (297 staff non-compliant)	• Some historical non-compliance dating back to 2024	• Essential Learning Oversight Group • Non Clinical Portfolio Governance Board • People & Culture Group
F. Implement the new NHS anti-racism bitesize module when released	Aligned	• Strong engagement with NHSE Statutory & Mandatory Reform project • NHSE propose bitesize module (3-4 mins) awaiting approval and release	• Implement on release	• Essential Learning Oversight Group • Non Clinical Portfolio Governance Board • People & Culture Group

NHS England Requirement	Alignment Status	Current Position	Gaps/Further Work Required	Governance
G. Ensure Board agreement to undertake anti-racism training when available	Aligned	• Board commitment to anti-discrimination and anti-racism • Board receives regular equality, inclusion and workforce culture updates	• Gain Board commitment to undertake training when available	• Trust Board • Essential Learning Oversight Group
H. Ensure colleagues, staff representatives, patients and communities are aware of actions being taken and are appropriately engaged	Partially aligned	• Established engagement mechanisms through Equality Support Networks, WRES engagement activity, consultation exercises and wider organisational communications • External web content and press releases	• Develop communications and engagement plan aligned to Lord Mann recommendations • Engage with the Critical Friends Network (Patient Experience) ensuring ethnically diverse representation	• Diversity & Inclusion Steering Group • People & Culture Group • YAS Together Programme Group
I. Ensure Board and relevant committees understand staff survey data relating to racism and are taking action	Aligned	• Workforce equality metrics and Staff Survey data are reported through existing governance arrangements, including WRES reporting and ethnicity pay gap data • Specific NSS ethnicity data shared with the Race Equality Network	• Opportunity to strengthen visibility of racism-related indicators, actions and progress monitoring.	• Diversity & Inclusion Steering Group • People & Culture Group • People Committee • Trust Board
J. Confirm adoption of the IHRA definition of antisemitism	Aligned	• International Holocaust Remembrance Alliance (IHRA) Definition of Antisemitism adopted December 2025	• Definition adopted, to be further embedded as part of the Anti-Racism work.	• Diversity & Inclusion Steering Group • People & Culture Group

NHS England Requirement	Alignment Status	Current Position	Gaps/Further Work Required	Governance
				• YAS Together Programme Group

Appendix C; NHS Race and Health Observatory, Seven Anti-Racism Principles



To:
- NHS chief executives

cc.
- Chief people officers
- Chief nursing officers
- Medical directors
- Communications directors
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 June 2026

Dear colleagues,

Lord Mann Review

Today Lord Mann has published his review into tackling racism and antisemitism within the NHS with recommendations to support our shared goal of making our services safe for all patients, communities and colleagues.

Some of the events we see at home and abroad – not least of all the distressing events surrounding the death of Henry Nowak – can polarise opinions and harden division, going against the values that make the NHS what it is.

As the NHS, we can – and often do – create an environment where every person, patient or colleague feels treated with dignity, compassion and respect.

Today's review demonstrates that we are not achieving that consistently and as effectively as we should be. Just like wider society, the NHS is not immune to the persistent and systemic challenges of all forms of racism (including antisemitism and Islamophobia), discrimination and inequality, and we all have much more to do.

These recommendations will help us strengthen the way we drive change, and our focus should be ensuring that we are a place of compassion, care and unity – not conflict or discrimination, every day, on every site, in every home we visit, in every shift. Achieving this requires us all to be honest about the challenges we face and take strong action to address them.

Lord Mann's review set out a range of recommendations for NHS England, NHS organisations and leaders, the Department of Health and Social Care, as well as arm's-length-bodies (ALBs) and regulators. Collectively, these measures aim to:

- strengthen leadership and accountability,
- improve understanding and capability through training and development,
- set clear expectations regarding political identifiers and inclusive practice,
- improve and standardise support and protection for staff who experience racism,
- improve the consistency, quality and application of data relating to racism.

As NHS England, we welcome the recommendations and we accept the recommendations for us in full. As an immediate set of actions, we will:

- sign up to the NHS Race and Health Observatory Seven Anti-Racism Principles
- set clear Staff Standards relating to experience of racism
- support NHS improvement and assurance through the NHS Oversight Framework
- strengthen accountability for racial inclusion through our appraisals
- consult on adding Jewish and Sikh to NHS protected characteristic datasets
- develop bespoke eLearning for NHS PALS and complaints handlers
- ensure all NHS boards and system leaders complete regular anti-racism training

We also know the display of politicised badges and symbols has been a matter of debate and concern for staff and patients. We will complete engagement and publish the long-awaited national uniform guidance in short order.

Tackling all forms of racism within the NHS will require a joined-up, concerted effort at every level – we should all be acutely aware of the racial abuse and harassment our colleagues and patients are subject to. Our own staff surveys give clear voice to some of the unacceptable discrimination and abuse faced within our organisations. In addition, it is just as concerning when we see evidence of discrimination in our services or hear testimony from patients who have experienced unequal treatment or antisemitic or racial abuse when interacting with the NHS. We also know that we must better support staff when they experience racism in their interactions with the public.

We have set out a series of immediate actions we are asking you to take within your own organisations:

- To join NHS England in signing up to the NHS Race and Health Observatory Seven Anti-Racism Principles.

- Ensure implementation of the Violence Prevention and Reduction Standard, including data capture and use to target improvement with affected groups, this will be monitored via the NHS Oversight Framework.
- Prepare to implement the forthcoming NHS Staff Standards.
- Adopt the new government definition of anti-Muslim hostility.
- Ensure all staff have completed the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes content on antisemitism and Islamophobia.
- Ensure all staff complete the new bitesize module co-created with faith leaders in the NHS when it becomes available (with the exception of those who have completed EDHR mandatory training in the last 6 months).
    - Ensure Board agreement to undertake new anti-racism training when it becomes available.
- Ensure colleagues, staff representatives, patients and communities are aware of your actions through your internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally.
- Ensure your Board and its relevant committees fully understand your staff survey data on the experience of racism in your organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress.

In addition, following on from our communications in October 2025, please can you confirm whether your organisation has adopted the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility. Please respond to this request, once for each organisation, by Friday 31 July 2026.

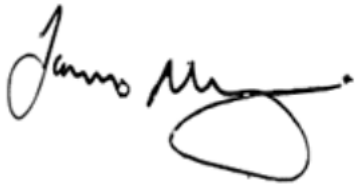
We know many organisations are already taking clear action, working in partnership with patients, community, trade unions and colleagues with lived experience – acknowledging and seeking to understand that experience is crucial to making the improvements we all want to see.

There are some fantastic examples of the work you are doing to tackle issues of racism and unequal access to services, and we'll work with you to share these widely across the system whilst encouraging you to use and support the delivery of the NHS equality, diversity and inclusion improvement plan.

Antisemitism and all forms of racism have no place in the NHS. Patients should never feel anxious when receiving care and no member of staff should ever feel isolated, intimidated or unwelcome in their workplace. The Lord Mann review gives us the opportunity to raise our standards and expectations about what we will accept and put our professional values –

care, compassion and clinical excellence first. It is part of every leader's role to actively begin to dismantle the structural discrimination which exists. We are grateful for your support in delivering the actions set out.

Yours sincerely,



Sir Jim Mackey
Chief Executive
NHS England

Danny Mortimer
Director General for People
NHS England

Board of Directors Meeting (in Private)
23 July 2026

Report Title	Ask Peter – Review and Update
Author	Andrew Johnson, Senior Internal Communications Manager
Accountable Director	Peter Reading, Chief Executive
Previous committees/groups	Trust Executive Group
Recommended action(s)	Information and assurance
Purpose of the paper	This paper provides a review of the 'Ask Peter' channel of engagement for staff and an update on activity and themes raised.

Executive Summary

This paper provides an update on the Ask Peter staff engagement channel, which enables colleagues to raise questions directly with the Chief Executive, anonymously where appropriate. Between November 2025 and June 2026, 129 questions were received, demonstrating continued use of the channel and providing insight into the issues of importance to colleagues.

The main themes related to operational matters, fleet and estates, HR, uniform and digital changes, with questions also highlighting opportunities to clarify processes, address concerns, dispel rumours and support timely improvements.

The continued use of Ask Peter for both general and sensitive individual matters provides assurance that colleagues value the route as a trusted, visible and responsive mechanism for listening and engagement.

The Board is asked to note the update and the ongoing role of Ask Peter in supporting an open and positive workplace culture.

Recommendation(s)	It is recommended that the Board note the update on the Ask Peter channel of engagement for staff.

Link to Board Assurance Framework Risks (board and level 2 committees only)	6. Develop and sustain an open and positive workplace culture. Choose an item. Choose an item.

Ask Peter – Review and Update

1.0 INTRODUCTION

1.1 Ask Peter is a channel of engagement for colleagues and provides a direct link to the Chief Executive. Colleagues can ask questions on any topics and can do so anonymously if they wish. It was launched in March 2024 as part of the Chief Executive's and Trust's commitment to ensuring there is a culture where people are listened to and encouraged and enabled to speak up.

1.2 Access to the channel is via a simple online form, available via a dedicated Pulse page that outlines the process and has a repository of all previous questions and responses, grouped into broad topic areas.

1.3 Each question is received directly by the Chief Executive and Corporate Communications team. The target to respond is within two-three weeks, however more complex questions can take longer to collate the necessary information. If a question can be answered by a process already in place, staff are directed to that, or to any similar question that has already been answered.

2.0 UPDATE ON ACTIVITY AND KEY THEMES – NOVEMBER 2025-JUNE 2026

2.1 129 questions were received between 1 November and 30 June 2025, separated into the following broad topics:

Finance	1
Fleet and estates	26
HR	20
Digital ICT	13
Operations General	1
Operations A&E	35
Operations EOC and IUC	8
Operations PTS	1
Uniform	18
Other	6
Total	**129**

2.2 There is generally a steady flow of questions being submitted, however at certain times during the year particular issues or topics can cause an increase in numbers being received in a short period. There continues to be a wide variety of topics and questions being asked, some of the key themes and questions of note from recent months include:

Uniform – the topic of uniforms continues to be a regular topic, but the specific details can vary widely. Over the last six months there were a number querying if fleeces could once again be part of the uniform offer. More recently there have been a small number of queries related to the heat weather and possible alternative uniform or particular groups of staff (e.g. in fleet workshops).

Digital updates – as there have been a number of changes introduced to digital systems, tools and processes over the last year, there have been a range of questions submitted in relation to these. This includes the roll-out of iPads and the updated ePR, and other system changes such as across Remote Patient Care.

Fleet – a constant theme of Ask Peter questions relates to the vehicles and supporting services across the Trust. The nature of questions can vary but recently has included air conditioning, the reliability of vehicles, equipment updates and maintenance schemes.

Operational issues – the majority of questions submitted continue to centre around operational issues. This has included:

- Late shift finishing and TOIL process
- Relief policy
- The use of JRCALC
- Mental health incidents.

2.3 Ask Peter continues to be used by colleagues to raise concerns in relation to personal issues/concerns, follow-up queries following a grievance, as well as a range of individual issues. In such instances, the questions and responses may be redacted/anonymised to protect those involved, or a direct line of communication established. This does highlight how trusted the Ask Peter process is and that colleagues have confidence in the system that it is anonymous when needed, their concerns are listened to, and that they will get a response and resolution where appropriate.

2.4 Some of the questions have provided an opportunity to address issues quickly, dispel myths/rumours, and change working practices. Recent examples include:

- A query of why newly qualified paramedics (NQPs) are often rotated with different crews and in some instances other stations, when they could be with regular crewmates. This provided an opportunity to explain the benefits of rotations and exposure to different working environments as part of the development of our NQPs.
- During the conflicts in the Middle East, there were a number of questions asked via Ask Peter and in other forums regarding our plans for potential fuel shortages and whether staff could access Trust stocks. This provided a valuable opportunity to not only outline that we were not currently expecting any shortages and that bunkered fuel levels were in a good position, but that we do have plans in place as part of our EPRR work should any experiences be issued to maintain our services.

3.0 OTHER ACTIVITIES

3.1 Maintaining a regular and visible presence of Ask Peter is key to its success. Therefore, we continue to promote the channel throughout the year. This includes:

- Summaries in Staff Update – covering latest topics, any themes and outcomes
- Updates in Teambrief Live
- Pulse homepage.

4.0 RECOMMENDATION

4.1 It is recommended that the Board note the update on the Ask Peter channel of engagement for staff.

Board of Directors (in Public)
23 July 2026

Report Title	Board Governance Report
Author	David O'Brien, Director of Corporate Services and Company Secretary
Accountable Director	David O'Brien, Director of Corporate Services and Company Secretary
Previous committees/groups	None
Recommended action(s) (assurance, approval, information)	Information. Assurance. Approval
Purpose of the paper	This report provides an update on issues and developments relating to Board governance.

Executive Summary

This report provides an update on matters relating to Board governance, as follows:

1. **Changes to Committee Chairs and Members:**
   - Michael Wright becomes the chair of the Finance and Performance Committee.
   - Michael Wright becomes a member of the Remuneration and Nominations Committee.
   - Michael Wright becomes a member of the Charitable Funds Committee.
   - Tabitha Arulampalam becomes the chair of the Charitable Funds Committee.

2. **Non-Executive Director Lead Roles**
   - Michael Wright has become the NED Champion for the Pride@YAS Network.
   - Michael Wright becomes the NED lead for sustainability.

3. **Fit and Proper Person Test Framework**

   NHS Trusts are required to submit an annual return to NHS England to confirm that all requirements of the Fit and Proper Person Test Framework have been met during the previous financial year. Confirmation that the Trust met the requirements for 2025/26 was submitted to NHSE ahead of the 30 June deadline. NHSE confirmed receipt of the submission with no queries.

Recommendation(s)	1. The Board confirms the changes to committee membership as set out in 2.1. 2. The Board confirms the changes to Non-Executive Director lead roles as set out in 2.2
Link to Board Assurance Framework Risks (board and level 2 committees only)	All BAF strategic risks

Board Governance Report

1. INTRODUCTION

1.1 This report provides an update on developments relating to Board governance.

2. BOARD GOVERNANCE UPDATES

2.1 Committee Chairs and Members

2.1.1 Following the retirement of Andrew Chang and the appointment of Michael Wright there are changes to some Non-Executive Director memberships of committees, as follows:

- Michael Wright becomes the chair of the Finance and Performance Committee.
- Michael Wright becomes a member of the Remuneration and Nominations Committee.
- Michael Wright becomes a member of the Charitable Funds Committee.
- Tabitha Arulampalam becomes the chair of the Charitable Funds Committee.

2.1.2 These changes took effect from 1 July 2026. The Board is asked to formally confirm these appointments.

2.1.3 Appendix A presents overviews of committee membership, effective from 01 July 2026 and until further notice.

2.2 Non-Executive Director Lead Roles

2.2.1 Following the retirement of Andrew Chang and the appointment of Michael Wright there are changes to some Non-Executive Director lead roles, as follows:

- Michael Wright becomes the NED Champion for the Pride@YAS Network.
- Michael Wright becomes the NED lead for sustainability.

2.2.2 These changes took effect from 1 July 2026. The Board is asked to formally confirm these appointments.

2.2.3 Appendix B presents an overview of Non-Executive Director lead roles, effective from 1 July 2026 and until further notice.

2.3 Fit and Proper Person Test Framework

2.3.1 NHS Trusts are required to submit an annual return to NHS England (NHSE) to confirm that all requirements of the Fit and Proper Person Test Framework have been met during the previous financial year. These requirements include the completion of annual checks, self-attestations, and appraisal processes for Board members.

2.3.2 For 2025/26 the Trust met these requirements. Confirmation of the Trust's position was submitted to NHSE ahead of the 30 June deadline. NHSE confirmed receipt of the submission with no queries.

2.3.3 A detailed report regarding the Trust's completion of the Fit and Proper Person requirements in 2025/26 will be submitted to the next meetings of both the Remuneration and Nominations Committee and the People Committee.

2.3.4 The Trust's processes and procedures for managing the Fit and Proper Person Test framework were subject to an internal audit review in 2025. This review reported significant assurance.

3. FINANCIAL IMPLICATIONS

3.1 This report has no direct financial implications.

4. RISK

4.1 Failure to develop and maintain effective Board governance arrangements for the Trust would present risks relating to strategic leadership capacity and capability, compliance with regulatory frameworks and codes (CQC Well-Led Framework, NHS Code of Governance, NHS Provider License, Provider Trust Capability Framework), and reputation.

5. RECOMMENDATIONS

5.1 The Board confirms the changes to committee membership as set out in 2.1.

5.2 The Board confirms the changes to Non-Executive Director lead roles as set out in 2.2

David O'Brien
Director of Corporate Services and Company Secretary

July 2026

APPENDIX A: COMMITTEE CHAIRS AND MEMBERS (Effective from 01 July 2026 and until further notice)

	Quality Committee	People Committee	Finance and Performance Committee	Audit and Risk Committee	Charitable Funds Committee
NED Chair	Becky Malbby	Tabitha Arulampalam	Michael Wright	Amanda Moat	Tabitha Arulampalam
NED Vice-Chair	Melanie Hudson	Amanda Moat	Saghir Alam	Tabitha Arulampalam	Michael Wright
NED Member	Amanda Moat	Melanie Husdon	Becky Malby	Saghir Alam	N/A[1]
Lead Director	Dave Green	Mandy Wilcock	Kathryn Vause	Kathryn Vause[2]	Kathryn Vause
Other Executive Member	Shona McCallum	Marc Thomas	Marc Thomas	David O'Brien[2]	Dave Green

1. There are two NED positions on the Charitable Funds Committee. This is under review and could be extended to three NED positions.

2. Kathryn Vause and David O'Brien are not members of the Audit and Risk Committee. Membership of this Committee is reserved for NEDs only.

APPENDIX A (cont.) COMMITTEE MEMBERSHIP 2026/27 (effective from 01 July 2026 and until further notice)

COMMITTEE MEMBERSHIP 2026-27	NON-EXECTIVE DIRECTORS							ANEDS		EXECUTIVE DIRECTORS / OTHER BOARD DIRECTORS									OTHERS	
COMMITTEE	Martin Havenhand	Amanda Moat	Michael Wright	Tabitha Arulampalam	Saghir Alam	Melanie Hudson	Rebecca Malby	Rebecca Randell	Katherine Lees	Peter Reading	Marc Thomas	Kathryn Vause	Dave Green	Shona McCallum	Amanda Wilcock	Carol Weir	David O'Brien	Samantha Robinson	Glen Adams	Helen Edwards
Audit and Risk Committee		C		VC	M							A					A			
Quality Committee		M				VC	C		A				M	M						
Finance and Performance Committee			C		VC		M				M	M				A		A		
People Committee		VC		C		M		A			M		A		M					
Remuneration and Nominations Committee	C	VC	M	M	M	M	M	A	A	A/M					A		A			
Charitable Funds Committee			M	C						A		M	M							A
Trust Executive Group										C	VC	M	M	M	M	M	M	M	M	M

Key: C = Chair, VC = Vice-Chair, M = Member, A = Attendee, ANEDs = Associate Non-Executive Directors

Note: Remuneration and Nominations Committee: the CEO is an attendee, but is regarded as a Member for items concerning the appointment or appraisal of Executive Directors

APPENDIX B:

NON-EXECUTIVE LEAD ROLES (effective from 01 July 2026 until further notice)

Lead Role	NED / ANED
Trust Deputy Chair	Amanda Moat
Senior Independent Director	Melanie Hudson
Freedom To Speak Up	Melanie Hudson
Safeguarding	Melanie Hudson
Health and Well Being Guardian	Tabitha Arulampalam
Emergency Preparedness, Resilience and Response / Security	Saghir Alam
Environment and Sustainability	Michael Wright
YAS Research Institute	Rebecca Randell

Staff Support Network Champions	NED
Pride@YAS	Michael Wright
Women and Allies	Melanie Hudson
Disabilities	Amanda Moat
Race and Equality	Tabitha Arulampalam
Armed Forces	Martin Havenhand

Integrated Care System Lead	NED
Humber and North Yorkshire	Amanda Moat
South Yorkshire	Saghir Alam
West Yorkshire	Tabitha Arulampalam

Board of Directors (in Public)
23 July 2026

Report Title	Assurance Committees' Annual Reports: 2025/26
Author	Lynsey Ryder, Head of Corporate Governance David O'Brien, Director of Corporate Services and Company Secretary
Accountable Director(s)	Committee Chairs (Non-Executive Directors) Committee Lead Directors (Executive Directors)
Previous committees/groups	People Committee Quality Committee Finance and Performance Committee Audit and Risk Committee
Recommended action(s)	Assurance
Purpose of the paper	Provide assurance regarding the effectiveness of the Board committees in their roles as part of the Trust's governance and assurance arrangements

Executive Summary

What?

As part of the Trust's corporate governance arrangements each of the Board assurance committees has prepared an annual report for 2025/26. Amongst other things, these annual reports provide assurance regarding the extent to which each committee fulfilled its purpose and remit in 2025/26 as defined by their Terms of Reference and captured in their annual workplan. These annual reports are enclosed as appendices to this cover sheet:

Appendix 1: Quality Committee Annual Report
Appendix 2: People Committee Annual Report
Appendix 3: Finance and Performance Committee Annual Report
Appendix 4: Audit and Risk Committee Annual Report

Each of these annual reports refers to further material (Committee workplans, ToRs etc.). In the interests of brevity that supporting material is not enclosed with these papers. However, it is available upon request should any Board member wish to receive it. Workplans and Terms of Reference have been reviewed and approved by each committee.

So What?

These annual reports provide assurance that the Trust's governance arrangements are working well and as intended. This constitutes one source of assurance for the Board regarding the effectiveness of the Trust's system of governance, assurance, and internal control.

What Next?

This exercise has identified improvement opportunities for each committee, and these will result in a stronger set of arrangements for governance and assurance in the Trust.

Learning from the recent Well-Led review will be used to inform further developments in the committee governance arrangements.

Recommendation(s)	The Board receives assurance via the 2025/26 annual reports of the Finance and Performance Committee, the Quality Committee, the People Committee, and the Audit and Risk Committee.
Link to Board Assurance Framework Risks (board and level 2 committees only)	All Strategic Risks

APPENDIX 1

The Quality Committee
Annual Report 2025-26

1. EXECUTIVE SUMMARY

1.1 This annual report provides a summary of the activity of the Quality Committee (the Committee) from April 2025 to March 2026 and an assessment of compliance against its terms of reference (ToR).

1.2 The self-assessment has been undertaken by the Committee Chair and lead Executive Director for consideration by the Committee. The self-assessment identifies 55 areas of compliance, four areas of partial compliance, and nine areas that were not applicable.

- The areas of partial compliance relate to use of data, information governance and health related IT clinical safety compliance, and timeliness of receipt of agenda items and minutes.
- The not applicable areas relate to external attendees, voting arrangements and urgent decision-making; these circumstances did not occur during the 2025-26 meeting cycle.

1.3 Meetings were well attended and all were quorate.

1.4 The Committee workplan has been adhered to. Following each meeting a Chair's 'AAA' ('Alert, Advise, Assure') report has been presented to the Board, drawing attention to matters of significance.

1.5 The Committee received Board Assurance Framework (BAF) updates at each meeting to review the effectiveness of controls for BAF risks within its remit, including access to care, quality for patients, medicines management, and reducing health inequalities.

1.6 Meeting effectiveness has been reviewed at each meeting. These reviews were generally positive with action taken on areas for improvement.

2.0 BACKGROUND

2.1 The Quality Committee is a standing committee that has been formally constituted by the Board of Directors of Yorkshire Ambulance Service NHS Trust (the Trust) in accordance with its Standing Orders.

2.2 The purpose of the Committee, in accordance with the 2025-26 ToR, is to gain assurance on behalf of the Board of Directors that the Trust is making sufficient progress towards its Quality priorities to support the delivery of the Trust's strategic objectives and business plan priorities whilst being assured as to compliance with appropriate regulatory and statutory requirements.

2.3 The purpose of the Committee is to seek and obtain assurance on behalf of the Board of Directors to demonstrate that the Trust:

- Is making sufficient progress towards improving patient safety, patient experience, and clinical outcomes, and reducing health inequalities.
- Is making sufficient progress towards the delivery of the Trust's strategic ambitions and business plan priorities in respect of the remit of the Quality Committee.
- Has in place the appropriate plans, policies, systems, data, intelligence and processes to support delivery of the above.
- Can be assured regarding compliance with appropriate policy, regulatory, and statutory requirements.
- Can be assured regarding the operation and effectiveness of systems of governance, risk management and internal control as they apply to the remit of the Committee.

3.0 ASSURANCE STATEMENT

3.1 The Committee receives assurance from the executive director members of the Committee and, from the subject matter experts who attend the meetings as required, dependant on the agenda items being discussed. Assurance is provided through written reports, both regular in accordance with the workplan and bespoke reports as requested, through challenge by members of the Committee and by members seeking to validate the information provided through wider knowledge of the organisation; specialist areas of expertise and attending Board of Directors meetings.

3.2 The Committee is assured that it has the right membership to provide the appropriate level and calibre of information and challenge and that the correct reporting methods, structures and workplans are in place to provide oversight on behalf of the Board in respect of progress and performance in the areas covered by its Terms of Reference.

3.3 Part of its assurance role is to receive the Board Assurance Framework (BAF); a primary assurance document for the Board which details the key controls in place to ensure that the risks to achieving the strategic objectives are being well managed. The BAF lists those Committees that are responsible for receiving assurance in respect of the effectiveness of those controls, the Quality Committee must ensure it receives sufficient assurance through the reports that come to the Committee in relation to:

- BAF Risk 2 – Provide access to appropriate care
- BAF Risk 3 – Deliver quality for patients
- BAF Risk 4 – Strengthen medicines management
- BAF Risk 11 – Collaborate effectively to improve population health and reduce health inequalities

The Committee received a BAF report at each meeting. In addition to the scheduled workplan reports, the Committee requested specific reports relating to controlled

drugs, alternative pathways, Category 2 response times, excessive delays, clinical response model, hear and treat performance and quality/safety oversight of the clinical queue.

4.0 REVIEW OF COMPLIANCE WITH TERMS OF REFERENCE

4.1 A self-assessment of compliance against all aspects of the ToR was undertaken by the Committee Chair and lead Executive Director.

4.2 There were 68 areas to be considered regarding the compliance or non-compliance of the Committee, against its terms of reference. The Committee was compliant with 55 areas. There were four areas of partial compliance and nine areas which were not applicable, as follows:

4.2.1 Partial Compliance

The timely and effective use of relevant and robust data and intelligence to drive improvement in the quality of care.

Whilst there is significant evidence of data being presented across a range of subjects, the requirement for an outcomes-focused quality dashboard has been identified. This work is being progressed with the support of the Committee, and regular progress updates are received.

The management and delivery of information governance and health related IT clinical safety compliance across the Trust's functions.

Partial compliance was assessed because information governance sits formally within the remit of the Finance and Performance Committee rather than Quality Committee and has therefore not been reported on. In addition, the absence of a Chief Clinical Information Officer (CCIO) limited the Committee's ability to gain assurance relating to IT clinical safety.

In the 2026/27 terms of reference, this requirement has been revised to refer to 'the management and delivery of digital clinical safety compliance across the Trust's functions'. A CCIO is now in post, and an annual assurance report on digital clinical safety has been incorporated into the Committee's workplan.

Items for inclusion on the agenda shall be submitted to the secretary at least seven days prior to the meeting. Agendas can only be amended by the agreement of the Committee Chair and Lead Director.

Agenda items were mostly received with seven days prior notice. Any amendments to agendas were agreed by the Committee Chair. Note full compliance during the tenure of the current Chair.

The Committee secretary shall minute the proceedings of all Committee meetings and provide draft minutes within five working days, reviewed by the Lead Director and then approved by the Committee Chair within 10 working days of the meeting.

Adherence to timescales was inconsistent throughout the year. Note full compliance during the tenure of the current Chair.

4.2.2 Not applicable

The areas assessed as not applicable relate to circumstances that did not arise during the year including the invitation to individuals from external organisations, the need for a vote, urgent decision-making, additional meetings, and the establishment of task-and-finish groups.

5.0 MEMBERS AND MEETINGS

5.1 Anne Cooper, Non-Executive Director, was the Committee Chair from April to November 2025. Becky Malby, Non-Executive Director, was the Committee Chair from December 2025 to March 2026.

5.2 During 2025-26 the Committee met formally on 11 occasions.

5.3 The quoracy for the Committee is three members, comprising at least two non-executive directors and one executive director present. The meetings were always quorate. The record of Members' attendance at meetings of the Committee during 2025-26 is shown at Appendix A.

5.4 The following individuals were in regular attendance during the year at the Committee's meetings:

- Phil Gleeson, Critical Friends Network member
- Lesley Butterworth, Head of Nursing and Patient Experience
- Jonathan Turnbull-Ross, Associate Director of Quality Improvement
- Tim Millington, Associate Director Paramedicine
- Adam Layland, Associate Chief Operating Officer – 999 Operations
- Julia Nixon, Associate Chief Operating Officer – Remote Care
- Katie Lees, Associate Non-Executive Director
- Lynsey Ryder, Head of Corporate Governance and Deputy Company Secretary

6.0 COMMITTEE WORKINGS

6.1 The Committee had an approved workplan for 2025-26 which included a calendar of key events that sets out the annual cycle of work and reporting. The workplan was kept under regular review and updated as required.

6.2 The Committee worked with other Board assurance Committees and regularly received matters for its consideration with referrals on matters made to other Committees for assurance purposes as and when required.

6.3 Prior to each meeting the Chair formally reviewed the agenda with the Director of Quality & Chief Paramedic and the Head of Corporate Governance/Deputy Company Secretary. Individual agenda items were consulted on with relevant responsible persons as required.

6.4 Following each meeting, the Chair reported to the Board, drawing attention to matters of significance. For example, the Board was alerted to excessive delays in Bradford, Calderdale and Kirklees (May 2025) and variation in availability of alternative pathways (January 2026). The minutes of the meetings were received by the Board at its meetings in private.

7.0 MEETING EFFECTIVENESS

7.1 Feedback on the Committee's effectiveness was largely positive. Administration was generally effective, agendas aligned well to priorities, papers were clear and structured, and chairing was praised as inclusive and effective. There was also strong focus on patient safety, staff perspectives, risk, constructive discussion, appropriate challenge, and a culture consistent with Trust values.

7.2 Areas for improvement included occasional administrative issues, lengthy or overly operational agendas and papers, and limited time for deeper discussion. Feedback also highlighted opportunities to strengthen patient voice, improve clarity around risk and risk appetite, and enhance executive-to-executive challenge. Overall, suggested improvements focused on tighter agenda planning, clearer papers and presentations, and better support for presenters.

7.3 Action has been taken to improve agenda management and the quality of papers, with particular focus on reducing the length of papers and strengthening executive summaries. These changes have led to noticeable improvements.

8.0 WORK OF THE COMMITTEE

8.1 During 2025-26 the Committee sought assurance of the overall delivery of the Trust's strategic objectives in the context of quality of care and services and the effective mitigation of identified risk. The main areas of reporting to receive this assurance were as follows:

<u>Regulatory:</u>

- Safeguarding
- Caldicott Guardian
- Complaints/Concerns/Comments/Compliments
- Medicines Optimisation and Controlled Drugs

<u>Assurance:</u>

- Academic Research
- Business Plan 2025/26
- Clinical Audit
- Clinical Supervision
- Coroners and Claims
- Health Inequalities
- Infection, Prevention and Control
- Learning from incidents

- Patient experience
- Patient safety
- Quality Improvement
- Risk and Board Assurance Framework
- Mortality/Learning from deaths

9.0 RECOMMENDATION

9.1 It is recommended that the Quality Committee reviews and agrees this annual report and self-assessment for presentation for assurance to the Audit and Risk Committee and Trust Board.

APPENDIX A: QUALITY COMMITTEE ATTENDANCE RECORD 2025-26

Quality Committee		Member Period	Meeting Dates										
			17-Apr-25	15-May-25	12-Jun-25	15-Jul-25	09-Sep-25	09-Oct-25	13-Nov-25	18-Dec-25	15-Jan-26	12-Feb-26	12-Mar-26
Anne Cooper	Chair, NED	April to November	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
Andrew Chang	Vice-Chair, NED	April to June	Apols	Apols	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Saghir Alam	Member, NED April to June Vice-Chair, NED July to Oct	April to October	Apols	Apols	Y	Y	Apols	Apols	N/A	N/A	N/A	N/A	N/A
Dave Green	Executive Director of Quality and Chief Paramedic	April to March	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Steven Dykes	Acting Medical Director	April to September	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A	N/A
Melanie Hudson	Vice-Chair, NED	November to March	N/A	N/A	N/A	N/A	N/A	N/A	Y	Y	Y	Apols	Y
Amanda Moat	Member, NED	July to March	N/A	N/A	N/A	Apols	Y	Y	Y	Y	Y	Y	Y
Shona McCallum	Executive Medical Director	October to March	N/A	N/A	N/A	N/A	N/A	Y	Y	Y	Y	Y	Y
Becky Malby	Chair, NED	December to March	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	Y	Y	Y

APPENDIX 2

The People Committee
Annual Report 2025-26

1.0 INTRODUCTION

1.1 This annual report provides a summary of the activity of the People Committee (the Committee) from April 2025 to March 2026 and an assessment of compliance against all areas of the Committee's terms of reference (ToR).

2.0 BACKGROUND

2.1 The People Committee is a standing committee of the Trust that has been formally constituted by the Board of Directors of the Yorkshire Ambulance Service NHS Trust (the Trust) in accordance with its Standing Orders.

2.2 The purpose of the Committee is to seek and obtain assurance on behalf of the Board of Directors to demonstrate that, in the context of the matters set out below, the Trust:

- Is making sufficient progress towards the delivery of the Trust's strategic ambitions and business plan priorities in respect of the 'Our People' bold ambition and the remit of the Committee.
- Has in place the appropriate plans, policies, systems, and processes to support delivery of the above.
- Can be assured regarding compliance with appropriate policy, regulatory, and statutory requirements.
- Can be assured regarding the operation and effectiveness of systems of governance, risk management, and internal control as they apply to the remit of the Committee.

3.0 MEMBERS AND MEETINGS

3.1 Tim Gilpin was the Committee Chair from April to July 2025, Tabitha Arulampalam has been the Committee Chair from September 2025 to March 2026.

3.2 During 2025-26 the Committee met formally on six occasions. All were ordinary meetings in accordance with the committee workplan and the Trust's cycle of corporate governance meetings.

3.3 The quorum for the Committee requires at least three Committee members to be present at each meeting. For the purposes of quoracy, the three Committee members present must include at least two Non-Executive Directors and one Executive Director, including either the Director of People and Organisational Development or the Deputy Chief Executive and Chief Operating Officer). The six meetings held during 2025/26 were quorate at all times.

3.4 The record of Members' attendance at meetings of the Committee during 2025/26 is shown at Appendix A.

3.5 In addition to the formal Committee Members, the following individuals were in regular attendance at the Committee meetings during the year:

- Suzanne Hartshorne, Deputy Director of People and Organisational Development
- Dawn Adams, Associate Director of People Development
- David O'Brien, Director of Corporate Services and Company Secretary
- Lynsey Ryder, Head of Corporate Governance and Deputy Company Secretary
- Rebecca Randell, Associate Non-Executive Director

3.6 Other senior managers (for example, Heads of Service and / or subject matter experts) have also been requested to attend the Committee throughout the year to discuss specific items including plans and projects within the remit of the Committee, including staff health and well-being, sickness absence, equality, diversity and inclusion, cultural development, Freedom to Speak Up, appraisals, essential learning, and the staff survey.

4.0 REVIEW OF COMPLIANCE WITH TERMS OF REFERENCE

4.1 A self-assessment of compliance during 2025/26 against all aspects of the ToR was undertaken by the Committee Chair and lead Executive Director.

4.2 There were 62 areas to be considered regarding the compliance or non-compliance of the Committee against its terms of reference. The Committee was fully compliant with 51 areas. There was one area of partial compliance and ten areas that were not applicable, as follows:

4.2.1 Partial Compliance:

> **The committee secretary shall minute the proceedings of all Committee meetings and provide draft minutes within five working days, reviewed by the Lead Director and then approved by the Committee Chair within 10 working days of the meeting.**

Adherence to timescales was inconsistent throughout the year.

4.2.2 Not applicable

The areas assessed as not applicable relate to the development of workforce submissions as this work takes place outside the Committee; and circumstances that did not arise during the year including the invitation to individuals from external organisations, the need for a vote, urgent decision-making, the need for additional meetings and the establishment of task and finish groups.

5.0 COMMITTEE WORKINGS

5.1 The Committee had an approved workplan for 2025-26 which included a calendar of key events that sets out the annual cycle of work and reporting. The workplan was kept under regular review, updated as required, and included as supporting material in the papers for each meeting.

5.2 The Committee linked with other Board assurance Committees as required, with referrals on matters made to other Committees for assurance purposes as and when relevant. For example, in the context of productivity and performance of ambulance crews some matters regarding rest break policy proposals were linked to the work of the Finance and Performance Committee.

5.3 Prior to each meeting the Chair formally reviewed the agenda with both the Director of People and Organisational Development and the Head of Corporate Governance/Deputy Company Secretary. Other relevant responsible colleagues were consulted on agenda items as required.

5.4 Following each meeting the Chair reported to the Board via the established 'AAA' report ('Alert, Advise, and Assure'), drawing the Board's attention to matters of significance. Minutes of the Committee's meetings were received by the Board.

6.0 REVIEW OF MEETING EFFECTIVENESS

6.1 There was a standing agenda item at the end of each meeting to evaluate and reflect on the effectiveness of the meeting. The key points raised during the year were as follows:

- There was broadly positive assessment of meeting effectiveness.
- Administration was generally strong, with papers circulated on time, technology used well, and agendas managed smoothly.
- Agenda items were seen as relevant, well-structured and aligned to the Committee's remit and strategic priorities, with a good balance of operational and strategic matters overall.
- Papers were usually clear and tailored to committee needs,
- The Chair was viewed as effective in leading focused, inclusive discussions and drawing out a range of perspectives.
- Staff voice was well represented, risk was appropriately embedded throughout,
- Discussions were open, constructive and respectful, reflecting Trust values and supporting effective assurance.

6.2 Some areas for improvement were identified, as follows:

- Feedback suggested that some agenda items and papers were too lengthy or operationally focused.
- There were also opportunities to strengthen direct patient voice and enhance the quality of executive summaries.

- While challenge was generally appropriate and assurance was usually achieved, executive-to-executive challenge was less evident in some areas.

6.3 Action has been taken to improve the quality of papers, with particular focus on strengthening executive summaries which has led to noticeable improvements. The use of the assurance structure 'what, so what, what next' has been more evident in papers and presentations.

7.0 WORK OF THE COMMITTEE

7.1 During 2025-26 the Committee sought assurance regarding sufficient progress towards the timely delivery of the Trust's strategic ambitions and business plan priorities, as well as compliance with appropriate regulatory and statutory requirements. Examples of the work carried out in relation to the purpose of the Committee as defined in the ToR are assurance reports covering:

- YAS Together and People Promise programme
- Health and Wellbeing plan
- Absence Reduction plan
- National Staff Survey engagement and improvement plans
- Equality, diversity, and inclusion
- Workforce Equality Standards (race and disability)
- Equality pay gaps (gender, race, and disability)
- Workforce planning
- Training plan
- Violence Reduction plan
- Employee Relations
- Fit and Proper Person Framework
- Nursing and Midwifery Job Evaluation National Audit

8.0 RECOMMENDATION

8.1 It is recommended that the People Committee reviews and agrees this annual report and self-assessment for presentation for assurance to the Audit and Risk Committee and Trust Board.

APPENDIX A: PEOPLE COMMITTEE ATTENDANCE RECORD 2025-26

People Committee Members		Membership Period	Meeting Dates					
			06-May-25	08-Jul-25	09-Sep-25	18-Nov-25	20-Jan-26	17-Mar-26
Tim Gilpin	Chair, NED	April to July	Y	Y	N/A	N/A	N/A	N/A
Amanda Moat	Vice-Chair, NED	Full Year	Y	Y	Y	Y	Y	Y
Andrew Chang	Member, NED	April to July	Apols	Apols	N/A	N/A	N/A	N/A
Mandy Wilcock	Member, Director of People and Organisational Development	Full Year	Y	Y	Y	Y	Y	Y
Nick Smith	Chief Operating Officer	April to November	Y	Y	Y	Y	N/A	N/A
Tabitha Arulampalam	Chair, NED	September to March	N/A	N/A	Y	Y	Y	Y
Anne Cooper	Member, NED	September only	N/A	N/A	Y	N/A	N/A	N/A
Melanie Hudson	Member, NED	October to March	N/A	N/A	N/A	Y	Y	Y
Marc Thomas	Member, Deputy Chief Executive & Chief Operating Officer	January to March	N/A	N/A	N/A	N/A	Y	Y

APPENDIX 3

The Finance and Performance Committee
Annual Report 2025-26

1.0 EXECUTIVE SUMMARY

1.1 This annual report provides a summary of the activity of the Finance and Performance Committee (the Committee) from April 2025 to March 2026 and an assessment of compliance against its terms of reference (ToR).

1.2 The self-assessment has been undertaken by the Committee Chair and lead Executive Director for consideration by the Committee. The draft self-assessment identifies 60 areas of full compliance, three areas of partial compliance, one area of non-compliance and nine areas that were not applicable.

- The areas of partial compliance relate to the timeliness of receipt of agenda items and minutes, and one aspect of onward reporting to the Board (one AAA report – from September 2025 - was not reported to Board in a timely manner).
- The not applicable areas relate to requests for assurance from other committees, external attendees, voting arrangements, urgent decision-making and task-and-finish groups; these circumstances did not occur during the 2025-26 meeting cycle.

1.3 Meetings of the Committee have been well attended and all were quorate. On one occasion a substitute NED member was required in order to secure a quorum.

1.4 The Committee workplan has been adhered to. Following each meeting a Chair's 'AAA' ('Alert, Advise, and Assure') report has been presented to the Board, drawing attention to matters of significance, with the exception of the September meeting as noted above.

1.5 Meeting effectiveness has been reviewed at each meeting; these effectiveness reviews were generally positive with action taken on areas for improvement.

2.0 BACKGROUND

2.1 The Finance and Performance Committee is a standing committee that has been formally constituted by the Board of Directors of Yorkshire Ambulance Service NHS Trust (the Trust) in accordance with its Standing Orders.

2.2 The purpose of the Committee is to seek and obtain assurance on behalf of the Board of Directors to demonstrate that, in the context of the matters set below, the Trust:

- Is making sufficient progress towards the delivery of the Trust's strategic ambitions and business plan priorities.

- Is making sufficient progress regarding the Trust's financial and performance targets, indicators, and outcomes.
- Has in place the appropriate plans, policies, systems, and processes to support delivery of the above.
- Can be assured regarding compliance with appropriate policy, regulatory, and statutory requirements.
- Can be assured regarding the operation and effectiveness of systems of governance, risk management, and internal control as they apply to the remit of the Committee.

3.0 MEMBERS AND MEETINGS

3.1 Amanda Moat was the Committee Chair from April to June 2025; Andrew Chang was the Committee Chair from July 2025 to March 2026.

3.2 During 2025-26 the Committee met formally on ten occasions.

3.3 The quorum for the Committee requires at least three Committee members to be present. For the purposes of quoracy, the three Committee members present must include at least two Non-Executive Directors and one Executive Director. The ten meetings held during 2025-26 were quorate at all times, although on one occasion a substitute NED member was required in order to secure a quorum

3.4 The record of Members' attendance at meetings of the Committee during 2025/26 is shown at Appendix A.

3.5 In addition to the formal Committee Members, the following individuals were in regular attendance at the Committee meetings during the year:

- Sam Robinson, Chief Digital Information Officer
- Louise Engledow, Deputy Director of Finance
- Carol Weir, Director of Strategy, Planning and Performance
- David O'Brien, Director of Corporate Services and Company Secretary
- Lynsey Ryder, Head of Corporate Governance and Deputy Company Secretary

3.6 Other senior managers (for example, Heads of Service and / or subject matter experts) have also been requested to attend the Committee throughout the year to discuss specific items including contracts, procurement, fleet, and estates.

4.0 REVIEW OF COMPLIANCE WITH TERMS OF REFERENCE

4.1 A self-assessment of compliance against all aspects of the ToR was undertaken by the Committee Chair and lead Executive Director

4.2 There were 73 areas to be considered regarding the compliance or non-compliance of the Committee against its terms of reference. The Committee was compliant with 60 areas. There were three areas of partial compliance, one area of non-compliance, and nine areas that were not applicable, as follows:

4.2.3 Partial Compliance

Items for inclusion on the agenda shall be submitted to the secretary at least seven days prior to the meeting. Agendas can only be amended by the agreement of the Committee Chair and Lead Director.

Agenda items were mostly received with seven days prior notice, but a small number were not. Any amendments to agendas were agreed by the Committee Chair.

The Committee secretary shall minute the proceedings of all Committee meetings and provide draft minutes within five working days, reviewed by the Lead Director and then approved by the Committee Chair within 10 working days of the meeting.

Adherence to timescales was inconsistent throughout the year.

Following each meeting of the Committee the Chair will report to the Board of Directors on how the Committee has discharged its responsibilities. Such reports will alert the Board to any matters that require action, advise the Board on other important matters, and assure the Board about the routine business transacted by the Committee.

Chair's reports were submitted and presented at the Board of Directors meetings in AAA format. The report from the September 2025 meeting was produced but was not reported to the following Board meeting. A process has been implemented to ensure AAA reports from committees are produced and submitted to the Board.

4.2.4 Non-compliance

The Committee Chair shall attend the Annual General Meeting of the Trust to respond to any stakeholder questions regarding the Committee's work during the year.

The Committee Chair registered apologies for the 2025 Annual General Meeting.

4.2.5 Not applicable

The areas assessed as not applicable related to circumstances that did not arise during the year including requests for assurance from other committees, the invitation to individuals from external organisations, the need for a vote, the need for additional meetings, decisions by email, and the establishment of task and finish groups.

5.0 COMMITTEE WORKINGS

5.1 The Committee had an approved workplan for 2025-26 which included a calendar of key events that sets out the annual cycle of work and reporting. The workplan was kept under regular review and updated as required.

5.2 The Committee worked with other Board assurance Committees with referrals on matters made to other Committees for assurance purposes as and when required.

For example, appropriate links were made with the People Committee regarding information governance training compliance, sickness absence, and paramedic vacancy rates.

5.3 Prior to each meeting the Chair formally reviewed the agenda with both the Director of Finance and the Head of Corporate Governance/Deputy Company Secretary. Other relevant responsible colleagues were consulted on agenda items as required.

5.4 Following each meeting the Chair reported to the Board, drawing attention to matters of significance, with one exception as detailed at point 4.2.1 of this report. Minutes of the Committee's meetings were received by the Board.

6.0 REVIEW OF MEETING EFFECTIVENESS

6.1 There was a standing agenda item at the end of each meeting to evaluate and reflect on the effectiveness of the meeting. The key points raised during the year were as follows:

- The evaluations indicate that Committee meetings were generally effective and well managed.
- Meeting administration was largely timely and efficient, with papers circulated on time and minutes and action logs appropriately reviewed and updated.
- Agendas were well aligned to the Terms of Reference, workplan and strategic priorities, achieving a good balance between strategic and operational matters while maintaining a clear focus on assurance.
- Papers were usually clear, concise and of an appropriate length to support effective discussion and decision-making.
- Chairing was consistently strong, with meetings generally running to time, discussions kept focused and inclusive, and actions clearly articulated.
- Members described the overall culture as respectful, constructive and aligned with Trust values, with open and transparent interactions between Executive and Non-Executive members.
- Risk was well embedded within Committee discussions, with regular review of mitigations, escalation of emerging issues and a strong emphasis on assurance.
- Debate and challenge were described as mature, supportive and appropriately focused on organisational priorities, performance and risk, with members participating actively and benefiting from cross-committee perspectives.

6.2 Some areas for improvement were identified, as follows:

- Executive summaries could be strengthened to better draw out the key messages rather than repeat the detail of full reports.
- Patient and staff voice was not yet consistently visible within discussions or reporting, highlighting an opportunity to strengthen how these perspectives are reflected in future meetings.

Action has been taken to improve the quality of papers, with particular focus on strengthening executive summaries which has led to noticeable improvements.

7.0 WORK OF THE COMMITTEE

7.1 During 2025-26 the Committee sought assurance of sufficient progress towards the timely delivery of the Trust's strategic ambitions and business plan priorities, along with consideration to the Trust's financial and performance issues and assurance as to compliance with appropriate regulatory and statutory requirements. Examples of the work carried out in relation to the purpose of the Committee as defined in the ToR are assurance reports covering:

- Revenue and capital planning
- Financial performance
- Operational performance
- Business planning
- Business plan performance
- Operational efficiency
- Review of contracts and variations
- Review of procurement strategies
- Review of business cases and tenders
- Relevant management group activity

8.0 RECOMMENDATION

8.1 It is recommended that the Finance and Performance Committee reviews and agrees this annual report and self-assessment for presentation for assurance to the Audit and Risk Committee and Trust Board.

APPENDIX A: FINANCE AND PERFORMANCE COMMITTEE ATTENDANCE RECORD 2025-26

Finance and Performance Committee Members		Membership Period	Meeting Dates									
			22-Apr-25	20-May-25	19-Jun-25	21-Jul-25	23-Sep-25	16-Oct-25	25-Nov-25	22-Jan-26	19-Feb-26	19-Mar-26
Amanda Moat	Chair, NED	April to June	Y	Y	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Saghir Alam	Member NED to Nov 2025 Vice-Chair, from Dec 2026	April to March	Apols	Apols	Y	Y	Y	Apols	Y	Y	Y	Apols
Tim Gilpin	Member, NED	April to July	Y	Y	y	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kathryn Vause	Executive Director of Finance	April to March	Y	Y	Apols	Y	Y	Y	Y	Y	Y	Y
Nick Smith	Chief Operating Officer	April to November	Y	Y	Y	Apols	Apols	Y	Y	N/A	N/A	N/A
Andrew Chang	Chair, NED	July to March	N/A	N/A	N/A	Y	Y	Y	Y	Y	Y	Y
Anne Cooper	Vice-Chair, NED	July to November	N/A	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A
Becky Malby	Member, NED	December to March	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	Y	Y
Marc Thomas	Deputy CEO and COO	December to March	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	Y	Y

APPENDIX 4

The Audit and Risk Committee
Annual Report 2025/26

1.0 Introduction

1.1 This report provides assurance that the Audit and Risk Committee has carried out its purpose and duties in accordance with its Terms of Reference (ToR).

1.2 The main focus of this report is the Committee's work during 2025/26. However the report also includes an initial commentary on the Audit and Risk Committee's year-end work during 2026/27 Q1 to conclude the governance, assurance, and reporting associated with the 2025/26 annual report and accounts.

2.0 Background

2.1 Under the NHS Code of Governance and other related regulatory frameworks each NHS trust is expected to include within its governance and assurance arrangements a formally constituted audit committee (or equivalent) that reports to its governing body. The Trust's Standing Orders 4.6 and 4.6.1 provide for the establishment of the Audit and Risk Committee to report direct to the Board of Directors.

2.2 The remit of the Audit and Risk Committee is formally agreed Terms of Reference and is consistent with the guidelines for NHS audit committees as set out in HFMA NHS Audit Committee Handbook (Fifth Edition, 2024).

2.3 This report primarily covers the work of the Audit and Risk Committee during the 2025/26 financial year. In particular, it addresses various matters for which the Audit and Risk Committee has oversight for the Board.

3.0 Members and Meetings

3.1 Standing Order 4.6.1 stipulates that the Audit and Risk Committee should be chaired by a Non-Executive Director. Throughout the period covered by this report the committee was chaired by Andrew Chang (April 2025 to June 2025) and Amanda Moat (July 2025 onwards), both Non-Executive Directors. Throughout this period the Executive Lead for the committee was Kathryn Vause, Executive Director of Finance.

3.2 During 2025/26 the Audit and Risk Committee met formally on five occasions as shown below.

- 29 April 2025

- 24 June 2025 (Annual Report and Accounts)
- 22 July 2025
- 11 November 2025
- 13 January 2026

3.3 All meetings were quorate. The meeting proceedings were managed in accordance with Trust Standing Orders and the Committee's Terms of Reference

3.4 Appendix A sets out the attendance record of the Members of the Audit and Risk Committee for the five meetings referenced in 3.2.

3.5 During the year the Committee held regular meetings in private with internal and external auditors.

4.0 Audit Committee Governance Arrangements

4.1 The Audit and Risk Committee operated in accordance with its Terms of Reference. For the 2025/26 financial year the Terms of Reference were reviewed and approved by the committee at its meeting held on 29 April 2025 and ratified by the Board on 22 May 2025.

4.2 The work of the Audit and Risk Committee is scheduled and delivered in accordance with an approved workplan derived from the committee's Terms of Reference. The workplan sets out an annual cycle of governance, assurance, and reporting. The workplan for 2025/26 was approved by the committee at its meeting held on 21 January 2025. The workplan is kept under regular review, retains sufficient flexibility to accommodate new requirements and ad hoc items, and is updated as required workplan.

4.3 The Audit and Risk Committee works with other assurance committees and the Trust Board. It receives matters for consideration from those bodies and refers matters to those governance bodies for assurance purposes as and when required.

4.4 Prior to each meeting of the Committee the Chair formally reviews the agenda with both the Director of Finance and the Director of Corporate Services and Company Secretary. Individual agenda items were consulted on with the relevant responsible person on an 'as needed' basis.

4.5 Following each meeting of the committee the Chair formally reports to the Board of Directors via a 'Triple A' (Alert, Advise, Assure) report.

5.0 Committee Effectiveness

Maturity Self-Assessment

5.1 During 2025/26 the Committee undertook a self-assessment review based on the audit committee matrix jointly developed by 360 Assurance and Audit Yorkshire in conjunction with the Good Governance Institute.

5.2 The assessment demonstrated that the Committee was in a stronger position compared to the most recent equivalent assessment carried out in 2023/24, with several examples of mature approaches and best practice. Identified areas of strength included:

- The Committee's clarity of purpose, objectives, and planning.
- The balance of skills, knowledge, and experience provided by Committee members and other regular attendees.
- The Committee's relationship with key governance and assurance documents and processes, including the Board Assurance Framework, the Annual Governance Statement, and the Internal Audit Plan.
- The strength and range of assurance provided by reports and information received by the Committee.
- The independence and effectiveness of the Committee
- The Committee's relationship with the Board and other committees.
- The Committee's relationships with internal audit, external audit, and counter fraud.
- The Committee's agenda, administration, and cycle of business.

5.3 The effectiveness exercise identified one main area about which the Committee could review and strengthen its current arrangements:

- To more clearly define the skills and experience required for Committee members and to ensure this is captured in the Board skills matrix and built into the induction, development, and succession planning arrangements for Non-Executive Directors.

Compliance with Terms of Reference

5.4 This annual report includes an assessment of the Committee's compliance with its own Terms of Reference for 2025/26. Appendix B sets out an analysis of this. Overall the committee demonstrated a significant level of compliance with its terms of reference during 2025/26.

5.5 Two areas of partial compliance or non-compliance were identified, as follows:

ToR Reference		**Compliance**
4.7.1(g)	The Committee will receive reports from the Charitable Funds Committee regarding governance, risk management, control, audit, and financial reporting matters	Partial
7.5	The Chief Executive shall attend meetings to discuss with the Committee the process for assurance that supports the Annual Governance Statement, to review each year's draft internal audit plan, and the draft annual accounts.	Partial

Meeting Evaluation Feedback

5.6 Meeting evaluation forms were completed and submitted for four meetings during 2025/26:

- 29 April 2025
- 22 July 2025
- 11 November 2025
- 13 January 2026

5.7 The main consistent themes emerging from these evaluation forms was:

- The chairing of meetings is effective, inclusive and engaging.
- Meeting agendas provide a good balance of strategic and operational issues.
- Papers are of good quality, providing the right level of detail (reflecting the complexity of the organisation) but also signposting to the key points.
- Members and attendees participate fully in discussions and reach decisions by consensus.
- The Committee has a culture of openness, honesty, and transparency. Executive colleagues take responsibility to own and resolve difficult issues.
- The Committee achieves appropriate assurance.

6.0 Key Work of the Committee

2024/25 Annual Report and Accounts

6.1 The Committee reviewed the Trust's Annual Report and Accounts for 2024/25 and recommended these for approval by the Board of Directors. The Committee also reviewed and received other items associated with year-end governance and reporting. The 2024/25 year-end items considered by the committee were:

- Annual Report
- Annual Accounts and Financial Statements
- Statement of Post-Balance Sheet Events
- Statement of Going Concern
- Annual Governance Statement
- Internal Audit Annual Report and Opinion
- External Audit ISA 260 (Audit Completion Report)
- Auditor's Annual Report
- Letter of Representations to the External Auditor
- NHS Code of Governance Compliance
- Board Members' Register of Interests
- Quality Account

6.2 Completion of the audit work on the annual report and accounts for 2024/25 was achieved on time. The Committee reviewed the 2024/25 annual report and accounts at its meeting held on 24 June 2025. Upon the Committee's recommendation, the Board of Directors approved the 2024/25 annual report and accounts on 26 June 2025.

External Audit

6.3. Throughout 2025/26 the Committee was advised by and received reports and technical updates from Bishop Fleming in their capacity as the Trust's external auditors. The Committee received the external auditor reports regarding the planning, completion and findings of audit of the annual report and accounts.

6.4 During 2025/26 the Committee undertook an effectiveness review of the Trust's external auditors. The findings of the review were positive. On this basis the Committee recommended that the Board approve a two-year extension to the contract for external audit provision.

Internal Audit

6.5 Throughout 2025/26 the Committee was advised by and received reports and technical updates from 360 Assurance in their capacity as the Trust's internal auditors. The Committee approved the 2025/26 internal audit plan, received regular updates on the progress of the plan, the findings of individual reviews, and the implementation of management actions arising from reviews.

6.6 The Committee received the Internal Audit Annual Report for 2024/25, including the Head of Internal Audit Opinion. For 2025/25 the Trust received an overall opinion of 'significant' assurance.

6.7 During 2025/26 the Committee undertook an effectiveness review of its internal auditors. The findings of the review were positive.

Counter Fraud

6.8 Throughout the year the Committee received advice and reports from 360 Assurance in their capacity as the Trust's counter fraud service provider. The Committee approved the annual Counter Fraud plan, received regular progress reports and updates, and received the Counter Fraud annual report.

6.9 The Committee approved the submission of the Counter Fraud Functional Standard Return for 2024/25 which confirmed full compliance with the Counter Fraud Functional Standard.

Governance, Risk Management and Internal Control

6.11 During the year the Committee received reports on various aspects of the Trust's system of governance, risk management and internal control. This included regular reporting of corporate risks and the strategic risks set out in the Trust's Board Assurance Framework.

6.12 The Committee reviewed and approved the Trust's Annual Governance Statement which sets out in detail the main features of the organisation's system of governance, risk management and internal control and how effectively these operated.

6.13 Financial controls routinely reviewed by the committee include contracts, single tender waivers, and special payments.

Assurance from Other Committees

6.14 Under its Terms of Reference the Audit and Risk Committee should expect to receive risk assurance reports and / or other reports from committees, as follows:

- Quality Committee
- Finance and Performance Committee
- People Committee
- Charitable Funds Committee

6.15 During 2025/26 the committee received quarterly risk assurance reports from the Quality Committee, the People Committee, and the Finance and Performance Committee.

6.16 The Committee received the Annual Report and Accounts for the YAS Charity. The Committee did not receive a routine assurance report from the Charitable Funds Committee. This will be reviewed during 2026/27.

7.0 URGENT AND FLEXIBLE DECISION MAKING

7.1 The Trust's Standing Orders allow for urgent and flexible decisions to be taken by the Chairs of Committees outside of the planned cycle of committee meetings. Such decisions should be ratified by the Committee at its next ordinary meeting.

7.2 During 2025/26 the Chair of the Audit and Risk Committee enacted no urgent or flexible decisions.

8.0 2025/26 YEAR-END

2025/26 Annual Report and Accounts

8.1 At its meeting held on 23 June 2026 the Committee reviewed the Trust's Annual Report and Accounts for 2025/26 and recommended these for approval by the Board of Directors. The Committee also reviewed and received other items associated with year-end governance and reporting. The 2025/26 year-end items considered by the committee were:

- Annual Report
- Annual Accounts and Financial Statements

- Statement of Post-Balance Sheet Events
- Statement of Going Concern
- Annual Governance Statement
- Internal Audit Annual Report and Opinion
- External Audit ISA 260 (Audit Completion Report)
- External Audit Annual Report
- Letter of Representations to the External Auditor
- NHS Code of Governance Compliance
- Board Members' Register of Interests
- Quality Account

8.2 Upon the Committee's recommendation, the Board of Directors approved the Trust's Annual Report and Accounts on 25 June 2026.

9. Retirement of Andrew Chang

9.1 Andrew Chang retired from the role of Non-Executive Director with the Trust on 30 June 2026, having served for six years.

9.2 Andrew had been Chair of the Audit and Risk Committee for five years, from June 2020 to June 2025. During the period July 2025 to June 2026 Andrew was Chair of the Finance and Performance Committee and the Charitable Funds Committee.

9.2 The Committee recognises and here formally records its thanks to Andrew Chang for his service to the Audit and Risk Committee and for his contribution to the governance and culture of the Trust more generally.

APPENDIX A: AUDIT AND RISK COMMITTEE ATTENDANCE RECORD 2025-26

Audit and Risk Committee		Membership Period	Meeting Dates				
			29-Apr-25	24-Jun-25	22-Jul-25	11-Nov-25	13-Jan-26
Amanda Moat	Member, April to June 2025 Chair, July 2025 onwards	Full Year	Y	Y	Y	Y	Y
Andrew Chang	Chair	April to June	Y	Y	N/A	N/A	N/A
Anne Cooper	Vice-Chair	April to June	Y	Y	N/A	N/A	N/A
Tabitha Arulampalam	Vice-Chair	July onwards	N/A	N/A	Y	Y	Y
Saghir Alam	Member	July onwards	N/A	N/A	Y	Y	Y